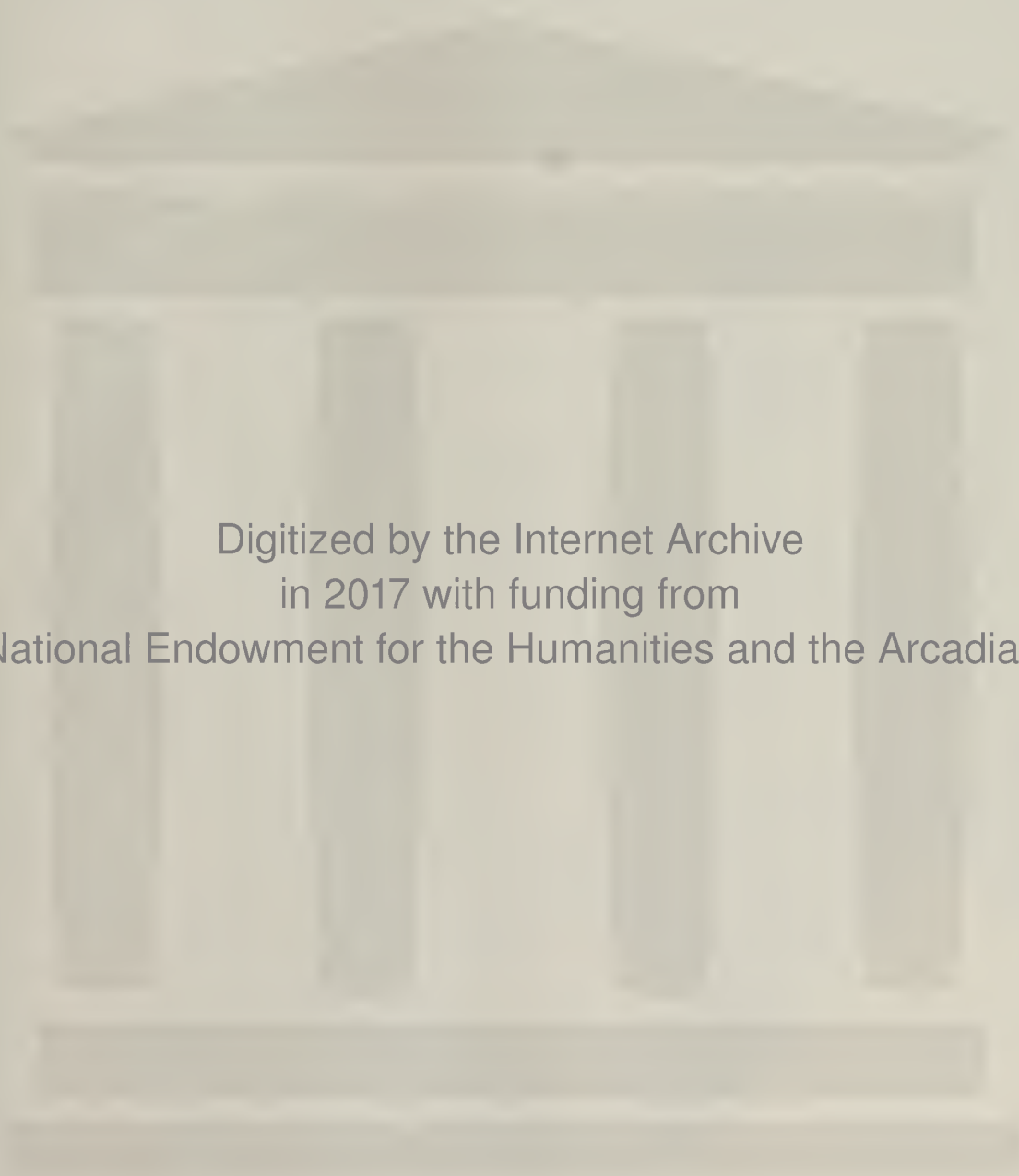


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KMA Legislative Handbook enclosed

JANUARY 1992

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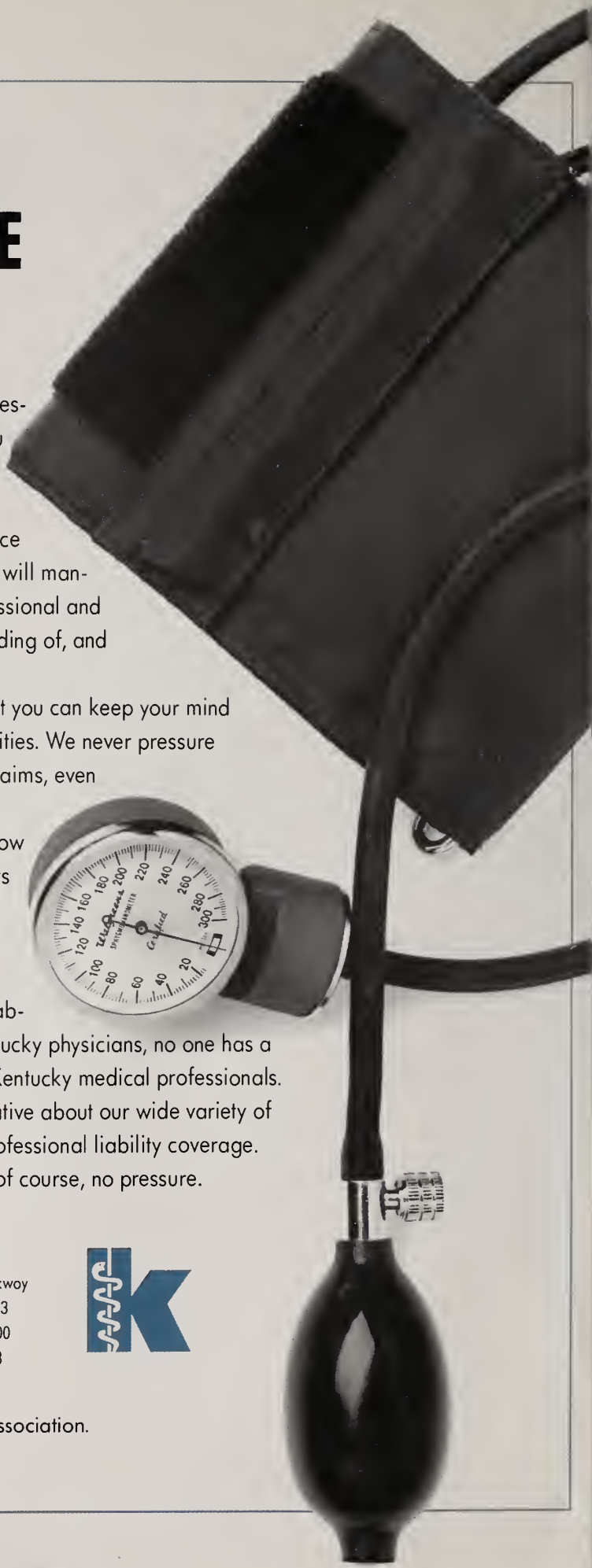
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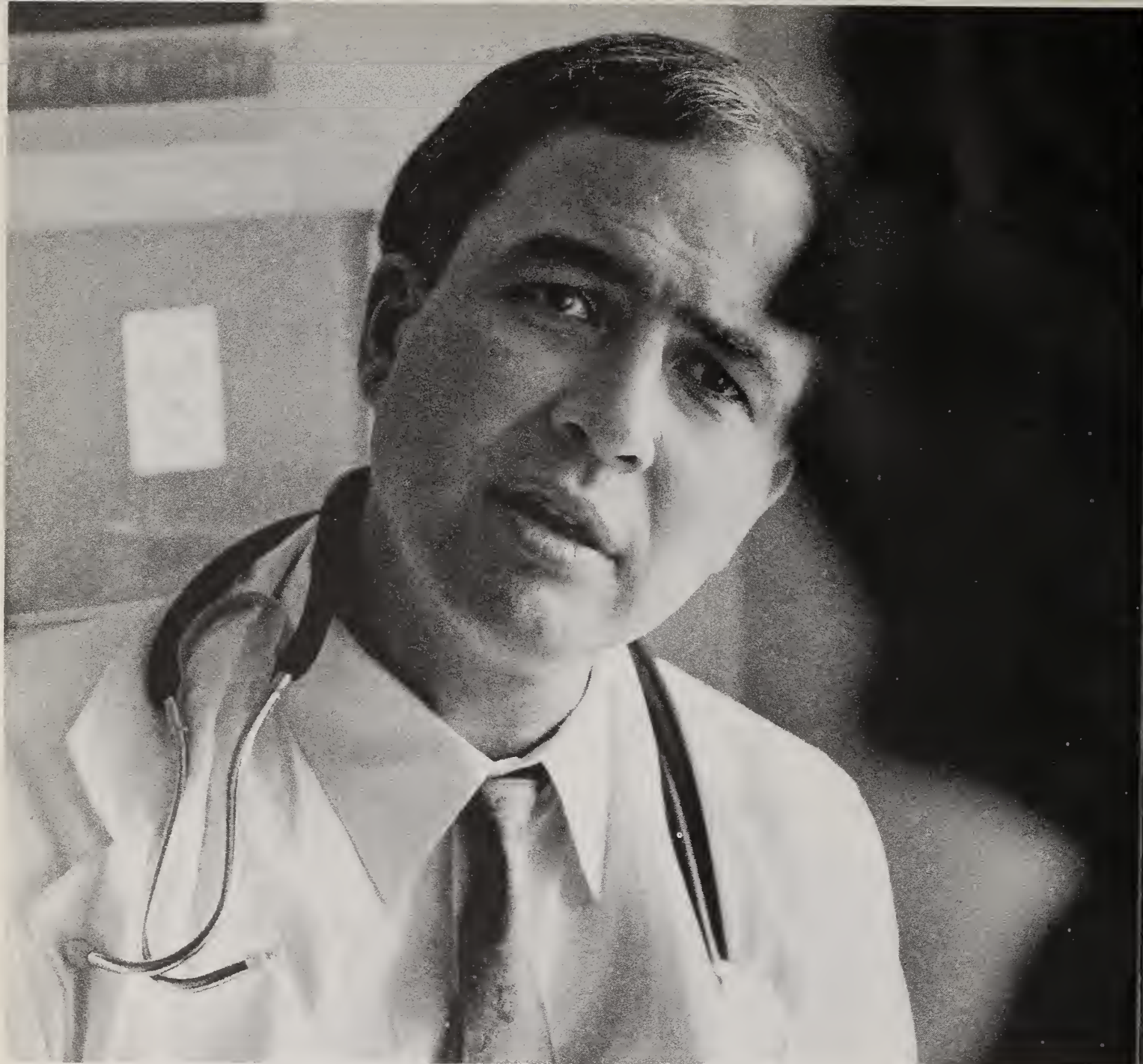
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"We must make sure that policies are based on facts, not fears."

Dr. Paul Volberding, Researcher, University of California, San Francisco, Member, American Medical Association

Amid the rancor of politics and budget debates, the needs of the patient are often overlooked. And, it is forgotten that it is physicians who know the most about disease and the suffering of patients.

Nowhere is this more true than with AIDS.

"Throughout the history of epidemics, there has been the possibility of reactions and policy based on fear and stigma," states Dr. Volberding.

The American Medical Association (AMA) agrees. The AMA is committed to fair AIDS policies, and to supporting researchers battling not just AIDS, but the countless diseases that ravage our society.

"What impresses me most about the AMA is its

willingness to take public policy positions and its ability to influence opinion," Dr. Volberding adds.

You are invited to join Dr. Volberding and to join with him in his efforts to bring quality health care to those in need. Become a member of the American Medical Association today.

Members of the AMA are encouraged to join their state, county and specialty societies.

American Medical Association

Physicians dedicated to the health of America



JOURNAL OF THE
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VOLUME 90, NUMBER 1

JANUARY 1992

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COVER: Pioneer physician Ephraim McDowell stands in the rotunda of the state capital amid some of Kentucky's most prestigious sons. President Abraham Lincoln stands in the center, surrounded by McDowell (monument in the background); Senator Henry Clay, Kentucky's most famous statesman; Jefferson Davis, President of the Confederacy during the Civil War; and Alben Barkley, US Vice President. The Kentucky General Assembly convenes in Frankfort this month. Enclosed with this issue of the Journal is KMA's 1992 Legislative Handbook.

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1992



Kentucky General Assembly 1992 Session

The governorship of Kentucky is no longer the all-powerful office it used to be. The legislature now can hold its own against a despot, as it proved in 1988 and 1990. The General Assembly will be co-equal with Brereton Jones or Larry Hopkins, neither of whom will want to defy it.

Hence, legislative committee meetings are of more use than gubernatorial candidate rallies or interviews in divining what state policy will be in the mid-1990s. And grass-roots local groups and statewide public-interest advocacy groups will be almost as important as elected officials as Kentucky enters its third century.

—ROBERT T. GARRETT

Courier-Journal Columnist

“We have progressed from a very simple agenda of water purification and health departments into the very complex considerations of medical insurance, medical assistance, and cost containment which is at the forefront this year.”

1992 marks a significant historical event in that our state is 200 years old. Our founding fathers established the constitution and the form of government we would abide by as a state. As you read this article the General Assembly has reconvened as it has done for 90 legislative days every 2 years to consider the business of this state.

The Kentucky General Assembly is comprised of 100 representatives and 38 Senators representing all areas of the state and many different professions and interests. It should be noted that we only have one

physician as a member of the Senate. This legislative body has changed from a Governor controlled and influenced body to a fiercely independent union over the past 10 years. The multiple committees function on an interim basis throughout the year with much of the work and background of legislative proposals formulated between sessions. The Kentucky Medical Association monitors the key committees of the Senate and House, such as the Appropriations and Revenue, Banking and Insurance, and Health and Welfare, and is continually involved with presenting testimony at hearings and helping to give advice to our representatives regarding medically related proposals.

For well over a century health problems have been a part of the KGA's laws and regulations. We have progressed from a very simple agenda of water purification and health departments into the very complex considerations of medical insurance, medical assistance, and cost containment which is at the forefront this year.

In the next few paragraphs note what we may expect to face in this session. At least one-third of the hundreds of bills and resolutions submitted will in some way be related to how we practice medicine and who will ultimately pay for the medical care of Kentucky citizens.

Liability reform will remain a

priority of KMA's efforts as directed by our House of Delegates. All of us involved with this reform package since 1976 are in agreement that only by changing Section 54 of our constitution can we get significant legislative relief. Such a constitutional amendment to be placed on the ballot will be achieved in one of these sessions and then we can ask the voters of this state to approve this amendment.

Health cost containment remains a priority of the majority of our legislators and there will be a major effort to pass some type of legislation requiring all providers to list their charges for comparison, including physician charges. This health data commission will be a very divisive problem among hospitals and physicians and this will be a fray in which our lobbyist and we must get involved in order to seek the best solution.

There will be a proposal for mandatory insurance coverage

“Liability reform will remain a priority of KMA's efforts as directed by our House of Delegates.”

provided by all businesses for their workers. This health insurance risk pool will serve as a detriment to many small businesses. We will find that the Chamber of Commerce and many other businesses in the state will find

“... there will be a controversy regarding physicians offices not being under CON and there will be proposals to require certain practices of physicians to fall under certificate of need even in their own office surroundings. Absolutely without exception we will oppose any effort by any group to bring physicians offices under certificate of need.”

that this is an onerous burden which will not be in the best interest of a good business climate. At the same time Workers' Compensation costs have been extremely escalating over the past several years, and again, we will be called on to help solve some of the problems associated with the cost for Workman's Compensation.

AIDS will be considered in a bill prepared by the Cabinet for Human Resources. Even with very good legislation passed in 1990, this bill will present many considerations which may be in direct opposition to some of KMA's policies. In this same vein there will be efforts made to require physicians to have continuing medical education on drugs.

Drug utilization and

appropriateness of prescriptions will be introduced. The complicated problem of therapeutic substitution would put us in direct conflict with the pharmaceutical companies and perhaps with the Kentucky Pharmaceutical Association. An attempt for para-medical personnel to practice medicine will be raised again in that RN practitioners will want legislation passed to allow them to write prescriptions. We have heard the rumors that nurses, optometrists, chiropractors, psychologists, and physical therapists all will seek to modify their practice acts.

Safety legislation again will be part of our KMA agenda and will be expanded to include boat safety and jet ski safety. Fayette County is the only metropolitan government in the state which requires seat belts, and it is our belief that KMA should make mandatory use of seat belts a priority which will be of tremendous benefit for the health and safety of Kentucky's citizens.

KMA will support the efforts to prohibit tobacco products from being made available to minors, as we believe this is a significant detriment to the health of Kentuckians; but this legislation will put us in direct conflict with many of our friends in the Kentucky General Assembly. However, we must adhere to the belief that in Kentucky tobacco is a major source of preventable health problems.

During our recent House of Delegates meeting the recommendation was that students in grades seven and eight should be barred from participating in varsity soccer, football, and wrestling. The committee on School and Medical Aspects of Sports has determined that

youth in the seventh and eighth grades suffer lifelong health problems participating in these varsity sports.

Certificate of Need (CON) took such a tremendous part of our time during the 1990 session and again will

“Don't be surprised during the 1992 session if legislation is introduced mandating that physicians participate in Medicaid and Medicare enforced by tying it to licensure.”

come up during the 1992 session of Kentucky General Assembly. We will find that there will be a controversy regarding physicians offices not being under CON and there will be proposals to require certain practices of physicians to fall under certificate of need even in their own office surroundings. Absolutely without exception we will oppose any effort by any group to bring physicians offices under certificate of need.

Don't be surprised during the 1992 session if legislation is introduced mandating that physicians participate in Medicaid and Medicare enforced by tying it to licensure.

Our approach to the 1992 session will be pro-active. Staff will be directed by EVP Bob Cox and Assistant EVP Bill Applegate from

Louisville and by Don Chasteen with the assistance of Brian Brezosky in Frankfort. In addition, our legislative consultants, Bill Doll and John Cooper, will be representing KMA full time during the session. The Quick Action Committee will meet weekly in Frankfort and our elected KMA officials and experts on different areas will be called on for testimony at crucial times. The key contact system is in effect with each legislator being linked with a physician of his choice who he can call on related to legislative proposals to give the view of the Kentucky Medical Association. The Auxiliary to the Kentucky Medical Association will be helpful to us in this session and will have their day in Frankfort on February 19, 1992. In addition, on January 22, 1992, there will be a legislative seminar in Frankfort, and it is my hope that many of you will attend this and become aware of the issues and the proposals that we have.

Each week you will receive a legislative bulletin, and I ask you to read this carefully to inform yourself of bills being considered and our official KMA position. Please use this information to personally speak with your Representative and Senator. With this issue of the *Journal* is a legislative handbook we have spent much time to produce. Keep it handy for your reference during the session. One nice spring day in April this session will be completed, and we can relax a little until the Interim Committees start their meeting.

Happy 1992 Kentucky General Assembly to each of you.

Wally O. Montgomery, MD, FACS
Chairman
State Legislative Committee

TOUGH, SMART AND YOURS

medical
economics
P-I-E

Successfully defending a brain-damaged baby case is the courtroom equivalent of pitching a no-hitter. Because the "sympathy factor" can add millions to a jury's award, many insurance carriers would rather settle than fight.

Not so the P-I-E Mutual Insurance Co. of Cleveland, Ohio and the 4-year-old law firm—Jacobson Maynard Tuschman & Kalur—that does all its defense work. In 21 brain-damaged baby cases it has defended for the doctor-owned company, its record is a remarkable 19-1-1, the last all-scores-and road 33 wins, 3 losses—all malpractice cases.

There's more to these numbers than luck. "We even legal skill," adds JMT&K founding partner Aaron Jacobson, who was one of Ohio's leading plaintiffs' lawyers before he, Larry E. Rogers, Herbert S. Bell, M.D., and 70 other Cleveland doctors formed P-I-E in 1975.

"It's the concept behind the firm that makes it work. Physician specialty panels review every lawsuit to decide whether the defendant deviated significantly from the standard of care. If he did, we pay. If he didn't, we defend. Makes no difference whether it's a \$5,000 or a \$5 million case. We label it 'No pay.' That policy has resulted in a lot of cases being dropped. Perhaps more important, it's

DON'T YOU WISH THESE DEFENSE LAWYERS WERE YOURS?

This big, multistate firm rarely loses a case. But it's more than luck, or even legal skill, that's behind its enviable record.

By Howard Eisenberg

discouraged the filing of many other cases. Plaintiffs' attorneys have learned that we're far negotiators when our doctors in the wrong but won't back down when he's right."

That approach pays off. "According to the most recent report I've seen from the General Accounting Office," says Larry Rogers, P-I-E president and CEO, "in 1984, about 55 percent of medical malpractice claims were closed without payment. Through 1988, we've closed an average of 78 percent of our cases without a dime changing hands. And it's my understanding that, without including defense costs, St. Paul Fire and Marine Insurance Co.'s 1988 average gross payout for cases closed in Ohio with payment was \$52,500. Our comparable figure was about \$10,000 below

theirs. That's partly why we can sell an ORG specialist in Ohio—an industrial state that ranks among the most litigious—\$1.2 million in coverage for just \$29,400."

The unique marriage of P-I-E and JMT&K has been so successful that the carrier has expanded into five other states: Indiana, Kentucky, Maryland, Missouri, and West Virginia. Where P-I-E goes, there goes JMT&K, with nine branches of five to date. The firm has 63 trial attorneys, and may well be the nation's largest devoted well-nigh exclusively to medical-malpractice defense.

Could the insurer-defender symbiosis, if duplicated by other doctor companies, make a significant contribution to reducing malpractice litigation nationwide? An up-close look at

how JMT&K operates may help to answer that question.

Every lawyer develops a medical specialty

"Our firm's lawyers read more medical books than law books," says P-I-E Vice President Gerald C. Oppenorth, himself a veteran defense attorney. Robert Maynard explains: "New cases are discussed at our weekly staff meeting, so that every lawyer is familiar with every case. But we assign cases to our attorneys according to medical specialty. They're well-versed in their fields, so they don't have to reinvent the wheel with each case."

Last year, the firm's ORG specialist, attorney Jerome S. Kalur, who had won 16 consecutive brain-damaged baby cases, faced one of his toughest challenges when he defended a GP

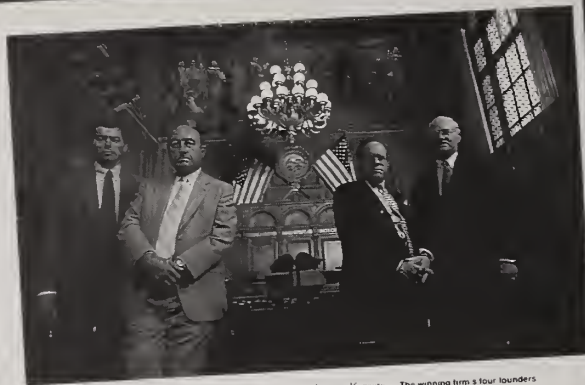
who'd attempted a malpractice delivery that ended in a Cesarean section and a severely brain-injured baby. Recalls Kalur: "I didn't think the doctor had caused the damage, but our position was weakened by the fact that he didn't have malpractice privileges. Based on that departure from the standard of care, our doctor panel voted to settle, and, since the hospital was also involved, a settlement sum of \$1.5 million was offered. Plaintiffs turned us down flat."

"I wanted to depose the doctor who'd been involved in the mother's care during her hospitalization, but the attorney for the plaintiff baby insisted it would violate the mother's physician-patient confidentiality. That privilege would terminate automatically when her medical

The winning firm's four founders at Cleveland's 8th District Court of Appeals (from left): Jerome S. Kalur, Aaron Jacobson, James M. Tuschman, and Robert Maynard.

records were introduced at the trial end of the plaintiff's case. Meanwhile, I was in the median position of having to tell the jury, 'It couldn't have been the malpractice,' without offering them another reasonable brain damage theory."

Fortunately, the plaintiff rested their case on a Friday afternoon, giving JMT&K time for a weekend rally. "Twenty minutes later," says Kalur, "I was in the hospital pathologist's office with an order permitting me to view the mother's placental slides." Necromum staining had been charted, and Kalur had a hunch that fetal distress had begun long before the for-



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The Antiphospholipid Syndrome: The Clot Thickens

Carolyn B. Gleason, MD; E. Nigel Harris, MD

The "Antiphospholipid Syndrome" is a disorder that mainly affects young people. Recurrent venous or arterial thrombosis, recurrent fetal loss, and thrombocytopenia are the primary features. The diagnosis is established by the presence of the anticardiolipin (aCL) antibody or the lupus anticoagulant (LA). Treatment is symptomatic.

Introduction

The "Antiphospholipid Syndrome" (APS) is a newly defined disorder that primarily affects young adults. These patients have antibodies to phospholipids present in the serum in high titer and can present with recurrent venous or arterial thrombosis and/or recurrent fetal loss.¹

There are numerous complications of this disease because clotting can occur anywhere in the vascular tree. Patients, therefore, can present to a variety of physicians. Often, they are first evaluated by their family physician for deep venous thrombosis, or they may be under the care of an obstetrician for multiple miscarriages. They may be seen by a cardiologist for myocardial infarction, a neurologist for stroke, or a hematologist in the course of evaluation for a hypercoagulable state. Most commonly, these patients are followed by a rheumatologist since about half of them will have systemic lupus erythematosus (SLE).

Case Report 1

The patient is a 29-year-old woman with a history of systemic lupus erythematosus (SLE) and hypertension who presented in 1987 at 3 weeks of gestation with complaints of polyarthralgias, blurred vision of the right eye, and poor memory. The past history was significant for periods of memory loss that had occurred over the 2 previous years. Psychometric testing was inconclusive and the memory deficits were attributed to active SLE.

She had been treated with prednisone 100 mg/day with some success and had tapered to 5 mg/day by the time of her initial visit. Physical examination was remarkable for a malar rash, a normal neurologic examination, and marked livedo reticularis of both the upper and lower extremities. The hemoglobin was 11.8 g/dl with a hematocrit of 36.4% and the platelet count was 114,000. The prothrombin time (PT) was 11.8 sec (control 11.8 sec) and the partial thromboplastin time (PTT) was 33.1 sec (control 26.0-36.0 sec). The IgG anticardiolipin test was >250 GPL units (negative is <5 GPL units). The ANA was 1:160, anti-double strand DNA and anti-Smith antibodies were negative. An MRI was performed and revealed 3 cm infarcts in the left frontal and both posterior parietal lobes, age undetermined. Based on the presence of unexplained cerebral infarcts associated with a high positive IgG anticardiolipin test, a diagnosis of the Antiphospholipid Syndrome was made.

The patient was treated with aspirin 325 mg/day and her pregnancy was uncomplicated until the second trimester when she developed mild proteinuria and worsening hypertension. The pregnancy ended in intrauterine death at the 24th week. Throughout her course the anticardiolipin antibody remained high positive.

In September 1988, the patient became pregnant again. At 6 weeks of gestation an empty gestational sac was seen on ultrasound; thus, she underwent a therapeutic abortion.

At this time, she is treated with aspirin 325 mg/day as stroke prophylaxis. She remains well although she has developed a seizure disorder that appears secondary to her previous strokes.

Case Report 2

The patient is a 28-year-old woman who was gravida 3, para 0, with a history of two spontaneous abortions at 6 and 8 weeks of gestation. On initial

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Antiphospholipid Syndrome

presentation in June 1988, she was 30 weeks pregnant and complained of severe left neck and shoulder pain, pleuritic chest pain, and intractable nausea and vomiting. Her past medical history was significant for recurrent deep venous thromboses (DVT) complicated by recurrent pulmonary embolism (PE). The physical examination was normal except for a temperature of 99.8°F, a resting tachycardia, and a Grade II/VI systolic murmur. Laboratory evaluation showed a hemoglobin of 12.5 mg/dl and a partial thromboplastin time (PTT) of greater than 100 seconds. The IgG anticardiolipin antibody was high positive at 139.7 GPL units (negative is less than 5 GPL units). The electrocardiogram and chest x-rays were normal. A fetal ultrasound showed no cardiac activity. The patient underwent laminaria placement and delivered a nonviable fetus weighing 2 lb 9 oz. Pathological examination of the placenta revealed extensive infarction, without evidence of abruption, and a three vessel cord. The patient was diagnosed with the Antiphospholipid Syndrome and was discharged on prednisone 20 mg/day and heparin 8,000 units subcutaneous tid.

Over the following months, prednisone was tapered to 10 mg/day and subcutaneous heparin was continued. In October of 1988, she experienced another DVT and heparin was increased to 10,000 units tid. The beta-HCG was positive. In December of that year, she had a fourth intrauterine death at 10 weeks of gestation. This delivery was complicated by a mild right cerebrovascular accident. Heparin was increased to 15,000 units tid. Throughout her course the anticardiolipin antibody IgG remained high positive.

Aside from occasional symptoms of headache and transient ischemic attacks, the patient's course was uneventful until the spring of 1989 when she became pregnant for the fifth time. This pregnancy was aggressively treated with prednisone, subcutaneous heparin, and intravenous immunoglobulin and resulted in the successful delivery of a son in January of 1990.

Currently she is doing well and is maintained on aspirin 325 mg/day.

History

Although the title "antiphospholipid syndrome" was not suggested until 1985, the constellation of symptoms was recognized much earlier. In 1952, Conley and Hartmann first noted the lupus anticoagulant reaction in two patients with SLE and a false positive serologic test for syphilis.² During

the 1970s came reports of miscarriage and by the early 80s, an association between the presence of the lupus anticoagulant and fetal loss was demonstrated.³

Many other symptoms have been suggested to be part of the syndrome. These include transverse myelitis, livedo reticularis, chorea, migraine headaches, and cardiac valvular lesions.

Antiphospholipid Tests

The antiphospholipid syndrome should be considered in the differential diagnosis for any hypercoagulable state. The work-up consists of two tests — the anticardiolipin antibody and the lupus anticoagulant. Because aPL antibodies are heterogeneous both tests should be performed.⁴ One test may sometimes be negative while the other is positive.

Lupus anticoagulant

The lupus anticoagulant test must be performed in three steps: (1) A prolonged clotting time must be demonstrated by the partial thromboplastin time (PTT), the Russell Viper Venom Time (RVVT), and/or the Kaolin Clotting Time (KCT). (2) The second step involves mixing patient plasma with normal plasma and repeating the clotting test. If the test is still prolonged, it suggests a clotting inhibitor is present (if it corrects, then prolongation of the clotting test in the first step is due to a clotting factor deficiency). (3) Prolongation is partially or totally corrected by the addition of phospholipids. This can be done with the addition of phosphatidylserine liposomes or by a platelet concentrate since platelets contain phospholipids.

Fig 1 shows the clotting cascade. It appears that aPL antibodies prolong clotting tests by their action at the level of the prothrombin activator complex (PAC). Interruption of the PAC delays fibrin-clot formation and therefore clotting times are increased.

Anticardiolipin test.

The anticardiolipin test is performed using the Enzyme-Linked Immunosorbent Assay (ELISA) technique. Microtiter ELISA plates are coated with a negatively charged phospholipid such as cardiolipin. Patient's serum is then added and if any aPL antibody is present, it will bind to the plate. Next, enzyme linked anti-human antibodies (IgM, IgG, or IgA) are added and they will bind

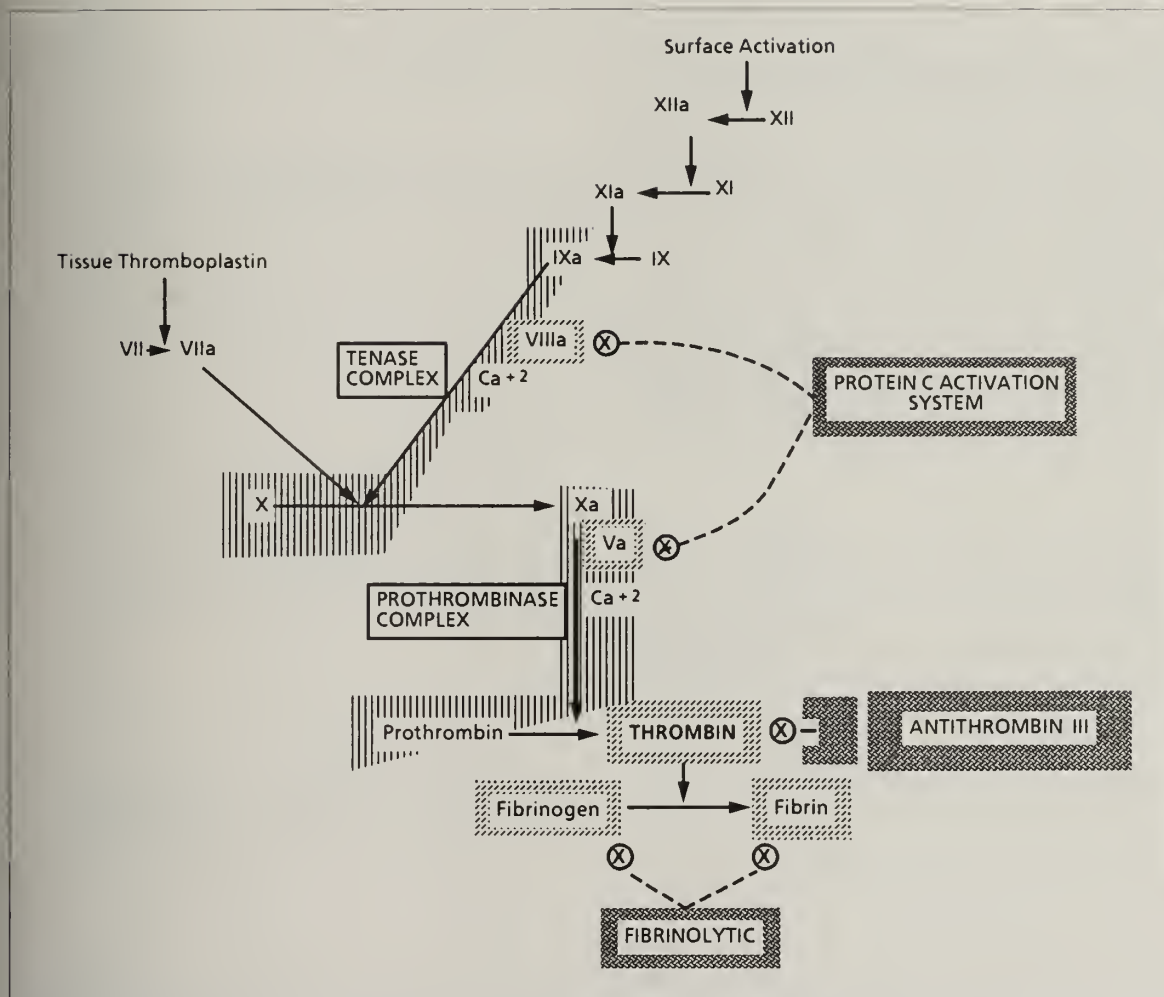


Fig 1 — Diagrammatic representation of the clotting cascade. The Tenase and Prothrombinase complexes as well as the protein C activation system are phospholipid dependent reactions. The fibrinolytic system, antithrombin III and the protein C activation system all inhibit clotting. Antiphospholipid antibodies may promote thrombosis by counteracting any of the inhibitors of the coagulation cascade.

any human antibody present in the wells. Lastly, enzyme substrate is added resulting in a color reaction that can be quantitated with a spectrophotometer. The color intensity is proportional to the amount of antibody that was bound (Fig 2).

VDRL

Although a sensitive test for syphilis, the VDRL is usually low positive or negative in patients with the APS and is therefore not a sensitive test for the latter disorder. The relationship between antibodies produced in syphilis and those produced in APS remains unclear. It appears that the VDRL can be positive in both diseases, but is caused by

different groups of antiphospholipid antibodies. Syphilis sera can also cause a false positive aCL ELISA test. The fluorescent treponemal antibody test (FTA) is negative in the APS (unless a patient has syphilis coincidentally!).

Clinical Features

The antiphospholipid syndrome is predominantly a syndrome of hypercoagulability. It should be suspected in any patient under 50 years old who has had recurrent venous or arterial thrombosis, myocardial infarction, stroke, or recurrent second or third trimester spontaneous abortions.

Antiphospholipid Syndrome

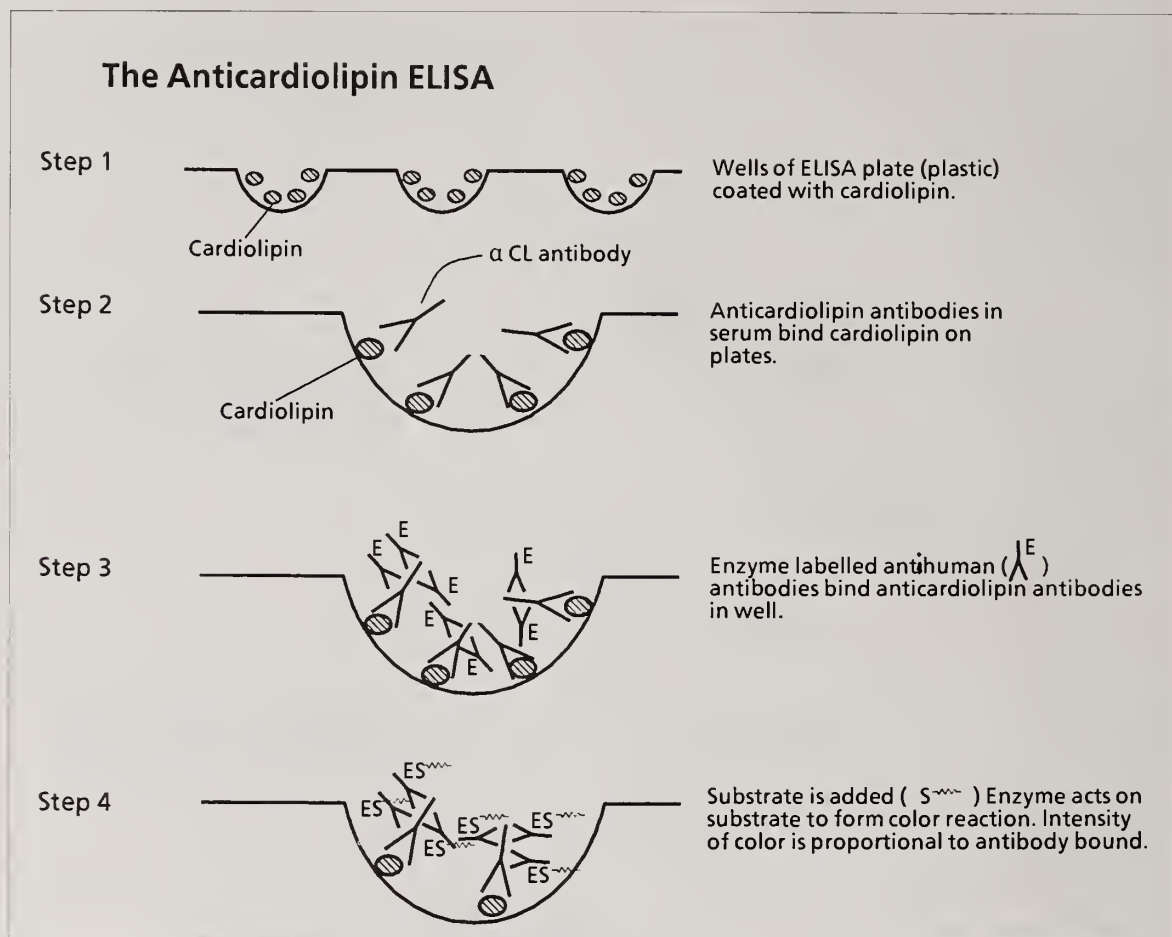


Fig 2 — Steps involved in the anticardiolipin test. Plates are coated with cardiolipin (step 1), then suitably diluted patient sera are added in duplicate (step 2). After incubation with patient sera, this material is discarded and enzyme-labelled anti-human antibody is added (step 3). After incubation, a substrate is added. If there is any enzyme labelled antibody in the wells, the enzyme will act on the substrate to cause a color reaction (step 4). The intensity of the color (read by a spectrophotometer) is roughly proportional to anticardiolipin antibodies in the well.

Thrombosis

Thrombosis may occur anywhere in the vascular tree in both the superficial and deep systems. The most frequently reported venous site has been the deep veins of the lower extremities with or without subsequent pulmonary embolism. Pulmonary hypertension has developed in some patients and is most likely the result of recurrent emboli. There have been isolated case reports of hepatic, adrenal⁵ and renal vein thrombosis as well as microvascular renal disease.⁶

Arterial thrombosis most commonly involves the intracerebral vessels and presents as strokes or transient ischemic attacks (TIAs). These, too,

are often recurrent. Over 45% of young patients with cerebral ischemia in one controlled study were found to have either aCL or LA positivity. Twenty-eight percent of the aPL positive group had recurrence within 1.2 years while none of the aPL negative patients recurred during the follow-up period.⁷

Arterial occlusion is believed to be thrombotic. However in one series of patients with limb loss as part of the syndrome, angiograms showed gradual narrowing of the involved arteries and pathological investigation showed intimal proliferation.⁸ More likely, both processes occur simultaneously.

Risk factors for thrombosis include surgery, prolonged bedrest, use of oral contraceptives, diabetes mellitus, smoking, and hypertension.

Recurrent fetal loss

Although fetal loss can occur at any stage of pregnancy in patients with the APS, it has classically been described during the late second or third trimester. The description of the APS has provided an explanation for recurrent miscarriages in some otherwise healthy women.

The placenta appears to be the site of the pathology. Examination shows thrombosis of placental vessels and placental infarction. The severity of these abnormalities is not always sufficient to explain fetal death. Other theories are that aPL antibodies cause developmental abnormalities in the placenta or that endothelial cell production of prostacyclin is suppressed. Prostacyclin is felt to protect against thrombosis by preventing deposition of platelet aggregates on the walls of the blood vessel.

Hematologic

As alluded to, the term "lupus anticoagulant" is actually a misnomer.⁹ Many of these patients do not have "lupus" (systemic lupus erythematosus) and despite a prolonged partial thromboplastin time, these patients rarely have a bleeding diathesis — hence, the inhibitor does not "inhibit clotting" in vivo as do other clotting factor inhibitors. Paradoxically, the lupus anticoagulant is associated with thrombosis.

Thrombocytopenia is a frequent complication in patients with the APS.¹ This can be intermittent or persistent. The course of thrombocytopenia is unknown but it has been suggested that aPL antibodies can bind phospholipids in platelet membranes resulting in platelet destruction.

Other features

Livedo reticularis results from vascular dilation in the skin causing a reticular pattern of bluish discoloration and is usually found on the thighs or forearm. It can be present in a variety of conditions including systemic vasculitis but is also present in otherwise healthy people. This skin abnormality has been described frequently in the antiphospholipid syndrome.

A few patients with the APS have been reported to have a variety of neurological abnormalities other than stroke. These include transverse myelitis, chorea, and even Guillain-Barre syndrome. These events occur so rarely in the

Table 1. Proposed Criteria for the Antiphospholipid Syndrome (APS)

Clinical	Serology
Venous thrombosis	IgG anticardiolipin antibody (>20 GPL units)
Arterial thrombosis	IgM anticardiolipin antibody (>20 MPL units)
Recurrent pregnancy loss	Positive lupus anticoagulant test
Thrombocytopenia	

Note: Patients with the APS should have at least one clinical feature and at least one serological test positive at the levels indicated. The serological test should be positive for a period greater than 8 weeks.

APS that one must wonder whether these are truly part of the disorder.

There have been numerous reports of cardiac valvular abnormalities. It is unclear whether the valvular abnormalities are truly related to aPL antibodies or simply a complication of SLE. Charash described 11 patients with SLE and aPL antibodies who had valvular disease.¹⁰ One of his patients required valve replacement, and on microscopy, the native valve showed Libman Sachs endocarditis. This type of endocarditis has classically been considered a complication of SLE. We are currently conducting a study to determine the frequency of valve abnormalities in patients with the syndrome.

Diagnosis

In 1987, diagnostic criteria were proposed for the APS.¹¹ Two subsets of patients emerged — those who did not have an associated autoimmune disorder and those who did. These have arbitrarily been separated into "primary" and "secondary" by some rheumatologists. However, there is currently no data to show that these two groups are in any way different as far as their risk for thrombosis and recurrent fetal loss is concerned.

Table 1 lists the clinical and serologic criteria for diagnosis. The antiphospholipid antibody test should be ordered as part of the work-up of a hypercoagulable state. Patients who have venous or arterial thrombosis, especially if under the age of 50, unexplained thrombocytopenia, a false positive VDRL test, or recurrent miscarriage should be tested.

The diagnosis can sometimes be difficult. Antibody levels appear relatively constant regardless

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of disease activity. There is the dilemma of how to interpret a low positive test in someone with thrombosis or pregnancy loss. We feel that patients should have at least one unequivocally positive serologic test and one clinical feature to confirm the diagnosis. Most patients, in our experience, have a combination of symptoms along with a moderate to high positive IgG aCL test.¹¹ A positive IgM aCL without a positive IgG makes the diagnosis questionable.

Mechanisms of Action

What role antiphospholipid antibodies play in the APS remains a subject of ongoing research and debate. It was first hypothesized that these antibodies suppressed prostacyclin production by endothelial cells resulting in increased platelet aggregation and thrombosis.

Some investigators have sought to determine whether the antibodies inhibit fibrinolysis. One researcher did show decreased plasminogen activator activity following venous occlusion of the arms of patients with SLE, but these results have not been confirmed by subsequent studies.¹² Others have postulated that there is a decrease in activation of protein C.¹³ Drs Marciniak and Romond of the University of Kentucky performed a series of elegant experiments which showed that aPL antibodies may inhibit inactivation of factor Va by protein C.¹⁴ Such inhibition may have a procoagulant effect. Most recently, it has been proposed that these antibodies interrupt the anticoagulant action of β 2-glycoprotein I. This is a plasma protein which interacts with phospholipids and is believed to have an anticoagulant effect.¹⁵ Since thrombocytopenia is a prominent feature of the syndrome, one wonders if the antibodies can bind platelets so causing their activation with resultant thrombosis. Anticardiolipin antibodies do bind to phospholipids on the platelet membrane, but it remains to be shown that platelet function is altered.¹⁶

Treatment

Treatment is uncertain since clinicians have only recently recognized this disorder. Recurrent venous thrombosis is probably best treated with long-term oral anticoagulation and/or antiplatelet agents. Patients with stroke or arterial thrombosis have been treated with aspirin alone, aspirin and dipyridamole, or oral anticoagulants. There is no data to show which regimen is best in preventing

recurrent arterial thrombosis. Recurrent events have occurred in some instances despite anticoagulant therapy.¹⁷ Although immunosuppression with corticosteroids, cytotoxic agents, or plasmapheresis has been successful in treating massive thrombotic events,¹⁷ prolonged use of these agents is not recommended.

Treatment for recurrent fetal loss has included high dose prednisone and aspirin, full dose subcutaneous heparin, or most recently, intravenous immunoglobulin. All three regimens have met with some success. There are plans for a multicenter trial to determine the treatment which will best insure successful pregnancy outcome.

Conclusions

The antiphospholipid syndrome is a relatively newly defined disorder. The common complications are now well accepted, but controversy remains regarding the association of less frequent findings such as Guillain-Barre, chorea, and cardiac valvular lesions. Much is yet to be learned regarding the pathogenesis, the origin of these antibodies, and the most appropriate treatment. There is considerable ongoing research on this subject, and we anticipate many answers in the upcoming years.

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Cushing's Syndrome Associated with Lung Tumors

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The production of corticotropin or corticotropin-releasing factor by non-pituitary, non-adrenal tumors may rarely be associated with an overt clinical expression of hypercortisolism. Recent studies have emphasized the importance of careful thoracic evaluation when such ectopic hormone secretion is suspected.

Introduction

Cushing's syndrome is suggested when a patient presents with hypokalemic alkalosis, fatigue, and the typical Cushingoid features of plethora, rounded facies, centripetal fat distribution, abdominal striae, and edema. The diagnosis is confirmed by documenting elevated levels of free cortisol in 24-hour urine collections after overnight dexamethasone suppression tests. A coordinated workup to establish the etiology of Cushing's syndrome is mandatory, since this disorder may be caused by glucocorticoid producing adrenal tumors, corticotropin producing pituitary adenomas, exogenous administration of glucocorticoids, and ectopic neoplasms that produce corticotropin or corticotropin-releasing hormone. A variety of stimulation and suppression tests have been devised and proposed to establish the underlying cause of hypercortisolism.¹

The finding of very low ACTH levels is evidence of a primary adrenal source of hypercortisolism. Such autonomously functioning adrenal tumors are either adenomas or carcinomas and account for 20% of the cases of Cushing's syndrome.

Cushing's syndrome with elevated ACTH production and bilateral adrenal hyperplasia is most often caused by pituitary disease, but 10% to 15% of such patients will have hypercortisolism from the production of ACTH or ACTH-like peptides by a nonendocrine tumor.² These tumors often contain cells from the amine precursor uptake

and decarboxylation (APUD) series and most commonly develop in the chest as small cell carcinomas, bronchial carcinoids, and thymic carcinomas.

We review the clinical and metabolic features of ectopic ACTH syndrome related to lung tumors and provide a current summary of the diagnostic and therapeutic options.

Case Report

The patient, a 53-year-old male, had been well until 3 weeks before admission when he experienced the onset of progressive diffuse muscle weakness and lethargy. He had developed a cough that was productive of yellow sputum. He reported a 30 pound weight gain during this interval that was associated with polydipsia, polyphagia, cold intolerance, and bilateral pedal edema. He denied fever, chest pain, exertional dyspnea, orthopnea and paroxysmal nocturnal dyspnea. His admission to our hospital was prompted by the onset of jaundice that had become apparent 3 days earlier.

He did not consume alcohol, but had accumulated a 90 pack-year history of tobacco use.

His oral temperature was 98°F. Blood pressure was recorded as 140/80 mm Hg and his pulse was regular with a rate of 88 BPM. He was in mild respiratory distress breathing 20 times per minute. He was alert and oriented. He had a Cushingoid facies, temporal muscle wasting, scleral icterus, and periorbital edema. Extraocular movements were normal without lid lag. The cardiopulmonary examination was normal and failed to document abnormal jugular venous distention. The abdomen was obese, distended, and tender in the right upper quadrant. Hepatomegaly was confirmed after the liver span was percussed to 20 cm in the midclavicular line. Hepatojugular reflux could be demonstrated. The spleen was not palpable. Nonpitting pretibial and pedal edema was

present. The lower extremities were covered with numerous ecchymotic areas (Fig 1).

Serum electrolytes were abnormal with a sodium of 133 mmol/L, a potassium of 2.1 mmol/L, a chloride of 81 mmol/L, and a bicarbonate of 42 mmol/L. Glucose was elevated to 155 mg/dl. Arterial blood gas analysis confirmed a significant metabolic alkalosis with a pH of 7.59. The PaO₂ was 67 mm Hg and the PaCO₂ was 39.8 mm Hg. Blood urea nitrogen was 34 mg/dl with a creatinine of 1.1 mg/dl. Random spot urine electrolytes measured the sodium <10 mmol/L, potassium at 55.3 mmol/L, and chloride <50 mmol/L. The pH of the urine was 5.0 and the specific gravity was 1.025. Trace amount of ketones, along with few red and white blood cells, were found in the urine sediment.

Additional laboratory suggested hepatic dysfunction with the LDH measured at 1164 U/L, SGOT at 262 U/L, SGPT at 801 U/L, and the alkaline phosphatase at 288 U/L. The patient's total bilirubin was increased to 5.0 mg/dl with a direct fraction of 4.5 mg/dl. His prothrombin time was 12.5 seconds and the partial thrombin time was 21.0 seconds. Serum protein was 6.0 g/dl with an albumin of 3.1 g/dl. Serum calcium was 9.2 mg/dl, phosphorus was 3.2 mg/dl, and his uric acid was 5.8 mg/dl. The patient's hemogram was remarkable for a total white blood cell count of 17,000 with 77% granulocytes, 4% band forms, 12% lymphocytes, and 7% monocytes.

Radiograph of the chest revealed blunting of the right costophrenic angle, fullness of the aortopulmonary window, and a nodule in the left midlung (Fig 2). A 2-D echocardiogram revealed normal ventricular function. An abdominal ultrasound demonstrated inhomogenous defects in the liver consistent with hepatitis or tumor metastases. The hepatitis profile was normal.

Endocrine workup consisted of a supine serum aldosterone that was elevated to 22.4 mcg/dl (normal 1-16), urine cortisol was 9600 mcg/24 hrs (normal 46-131) and serum ACTH was 241 picograms/ml (normal <70). A low dose dexamethasone suppression test was performed with a morning cortisol of 195 mcg/dl and ACTH of 398 pg/dl. High dose dexamethasone suppression test revealed a cortisol of 215 mcg/dl and an ACTH of 389 pg/ml.

Enhanced CT scan of the head was normal, but the CT scan of the chest revealed a large left hilar and mediastinal mass. Enhanced CT scan of the abdomen and pelvis revealed adrenal hyperplasia and ascites. Tissue identified as subepithel-



Fig 1 — Edema and ecchymosis of the lower extremities.



Fig 2 — PA chest film showing left hilar density.

Cushing's Syndrome

Table 1. Possible profiles of 24-hour urine concentrations of 17-hydroxy steroids to the overnight dexamethasone suppression tests.

	low dose dexamethasone administration	high dose dexamethasone administration
Normal persons	↓	↓
Pituitary CD	↑	↓
Ectopic CS	↑	↑

ial infiltrating undifferentiated small cell carcinoma was obtained at bronchoscopy.

Although immediate treatment with combination chemotherapy was initiated, the patient rapidly deteriorated from progressive hepatic, renal, and respiratory failure. He expired 10 days after admission, 4½ weeks after onset of his symptoms.

Discussion

The etiology of ACTH hypersecretion may be difficult to establish. The presence of corticotropin-dependent hypercortisolism has become easier to identify since the development of advanced monoclonal antibody tests,^{3,4} but clinical situations still arise that challenge the physician's diagnostic skills. Although the dexamethasone suppression tests remain the procedures of choice in most institutions (Table 1), 30% of patients with occult ectopic neoplasms will have dexamethasone-suppressible hypercortisolism and 15% to 30% of patients with pituitary Cushing's disease fail to show dexamethasone suppressibility.⁵

The metapyrone test is rarely employed, having been supplanted by reliable plasma ACTH assays. Use of the CRH stimulation test is recommended to improve the clinician's differential ability since the intravenous administration of CRH to patients with pituitary dependent ACTH secretion will have an increase in plasma ACTH and cortisol levels, while those patients with ectopic ACTH production are not expected to increase the plasma concentration of either compound. Several exceptions to this observation have also been recently reported.⁶ Interpretation of the data from both tests is often more helpful than either test alone.

Recent advances in invasive catheterization allow direct measurement of pituitary output by sampling the venous effluent from the inferior petrosal sinuses. The detection of a gradient between the ACTH concentration from the petrosal sinuses and peripheral blood establishes the secretion as being pituitary in origin.⁷ This test has emerged as the single most specific test for evaluation of the pituitary gland in Cushing's disease.

After biochemical and radiographic evaluation of the pituitary and adrenals, 85% of those patients with Cushing's syndrome secondary to ACTH hypersecretion will be found to have a pituitary corticotrophic adenoma (Cushing's disease). The other 15% will have an ectopic source of ACTH secretion, generally by tumors of the amine precursor uptake and decarboxylation system (APUD).⁸ These tumors most commonly develop in the thorax in the form of small cell carcinoma, bronchial carcinoid, and thymic carcinoma.⁹

Why certain non-pituitary tumors synthesize biologically active ACTH remains unclear, but the secretion of ACTH implies that other peptides may also be found in the circulation. While it has been suggested that all lung tumors of carcinoid or small cell histology synthesize ACTH-like materials, the clinical evidence of the ectopic ACTH syndrome is rare. The ACTH may be immunoreactive but not bioactive. Early reports on the prevalence of ACTH precursors in the plasma are contradictory because quantification was variable depending on antiserum specificity and the peptide used as the standard. Some of this confusion will be remedied by future studies using monoclonal antibodies in a two site immunoradiometric assay (IRMA).⁴

Several features distinguish ectopic ACTH syndrome from pituitary dependent Cushing's disease. There is a predominance of males in almost all series. The metabolic and symptomatic decline is very rapid and marked by severe muscle wasting and weakness. Hyperpigmentation, especially of the soft palate, in the absence of pituitary adenoma is considered an important diagnostic marker.¹⁰ The metabolic disturbances are more striking than with pituitary dependent Cushing's disease and is expressed as severe hypokalemic metabolic alkalosis, impaired glucose tolerance, personality changes, very high levels of plasma ACTH, and elevated serum and urine free cortisol levels unsuppressible by dexamethasone.¹¹

Another clue to ectopic production of ACTH is the appearance of the adrenal glands on CT of the abdomen. In classic pituitary dependent

Cushing's disease, 50% will have normal appearing adrenal glands and 50% will have mildly hyperplastic glands. The presence of bilateral nodular hyperplasia of the adrenals should suggest ectopic ACTH production.

Patients with ectopic ACTH syndrome may present with one of three profiles. The first presentation is Cushing's syndrome with a malignant tumor easily identified at about the same time. The highly malignant small cell lung cancer is usually apparent when hypercortisolism is documented. Small cell carcinoma of the lung accounts for 20% of all lung cancer and appears to be derived from the cells of the amine precursor uptake and decarboxylation series. Approximately 30,000 new cases occur in the USA each year. Although immunoreactive ACTH can be detected in almost all patients with small cell tumor, clinical or biochemical evidence of hyperadrenocorticalism occurs in less than 5% of patients.¹²

When small cell carcinoma is the etiology of ACTH production, the clinical appearance of Cushing's syndrome heralds the terminal event.^{13,14} Although these patients exhibit hypokalemia, weakness, muscle wasting, and metabolic alkalosis, the rapidity with which the syndrome develops usually precludes the development of the classic Cushingoid features of rounded facies, plethora, abdominal striae, and centripetal fat distribution.¹⁵ Our patient was unusual in this respect.

The second presentation may be Cushing's syndrome with an apparently benign tumor that requires a thorough investigation. As indicated earlier, the thorax requires the greatest scrutiny. The use of computerized chest tomography has proved effective and sensitive in detecting bronchial tumors and should be used early when evaluating a patient for a potential peptide secreting tumor. Interestingly, abnormal findings on routine chest radiographs occurred in only 36% of patients with Cushing's syndrome in one study. The abnormality was missed or misinterpreted in 20% of patients.¹⁶

Finally, patients may present with documented ectopic ACTH secretion for more than 6 months but without an obvious source despite repeated evaluation. It is imperative that the clinician recognize that the most common site remains the lungs and continued vigilance is required. Bronchial carcinoid will be the most common elusive tumor responsible for ectopic ACTH secretion.

These patients are slightly younger than

those with small cell carcinoma. The majority of patients will develop a Cushingoid appearance and experience muscle weakness and weight gain with edema and hypertension. Approximately one-half will develop hyperpigmentation. The mean delay in locating the occult tumor is roughly 36 ± 6 months. Forty to fifty percent of the bronchial carcinoids with ectopic ACTH secretion show suppression of ACTH/cortisol with the high dose dexamethasone test. This finding, which usually indicates a pituitary dependent ACTH secretion, has also been recognized with mediastinal carcinoid tumor. Instead, some carcinoids secrete CRH, which in turn stimulates pituitary secretion of ACTH.

The coordinated workup is often characterized by a normal appearing chest radiograph. Contrast CT scanning with 5 mm sections has emerged as the single best imaging procedure⁹ with MRI helpful if STIR sequencing is available. Bronchoscopy has been unrewarding and bronchial lavage fluid fails to detect elevated levels of ACTH.¹⁷ In the case of established ectopic ACTH production, continued surveillance of the chest should be maintained, because most patients with this syndrome will eventually manifest intrathoracic pathology consisting of a bronchial carcinoid or a thymic tumor.

The subgroup with ectopic ACTH production from occult tumors is in special jeopardy. The inability to locate the ectopic source leads to a high incidence of hypophysectomy and adrenalectomy without cure. Aggressive evaluation is preferable by a team approach to avoid unnecessary interventions. During the period of nondiagnosis, these patients are at risk for death from sepsis, gastrointestinal perforation, metastatic dissemination, and the biochemical ravages of the most severe form of endogenous hypercortisolism.

During the workup, suppression of cortisol secretion may be achieved pharmacologically with ketoconazole (600 mg/day) which effectively inhibits biosynthesis of cortisol by blocking adrenal 11 beta- and 17 alpha-hydroxylase activity and androgen synthesis.¹⁸ It is rapidly effective and has persistent efficacy with minimal tolerable side effects.¹⁹ This recommends ketoconazole as a preoperative treatment for Cushing's syndrome. Although not yet available in the USA, the antiprogesterin steroid RU 486 has been successfully used to treat hypercortisolism of patients with nonpituitary Cushing's syndrome.²⁰ Aminoglutethimide and metyrapone have also been effectively used

Cushing's Syndrome

to treat endogenous hypercortisolism, but side effects such as rash, pruritus, and hypertrichosis sometimes require that treatment be discontinued.²¹

When drugs are used to suppress ACTH effects on the adrenal gland and relieve hyperadrenocorticalism in patients younger than the age of 60 years, a rebound thymic hyperplasia is routinely expected after the correction of hypercortisolism with drugs or adrenalectomy.⁹ Therefore, the clinician must not assume that an enlarging thymic mass after suppression of elevated cortisol levels indicates the site of ectopic hormone production.

If hypercortisolism cannot be controlled during a prolonged unsuccessful search for the ectopic tumor, it may be necessary to resort to total adrenalectomy. This would provide provisional control of Cushing's syndrome, until definitive treatment can be exercised when the tumor makes itself evident.²⁰ Excision of nonmalignant ACTH-producing tumors generally provides a satisfactory long-term prognosis.^{8,22}

In summary, ectopic ACTH syndrome due to nonendocrine tumors may be indistinguishable from pituitary-dependent Cushing's syndrome (disease). When suggested in a male patient an ectopic neoplasm is likely and work-up should be directed to the respiratory tract. The clinician should consider ACTH producing bronchial carcinoids as different from the classic indolent bronchial carcinoid. The ACTH activity serves as a marker of more malignant and aggressive behavior with increased propensity for metastases to lymph nodes. They will require complete resection and follow-up.

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A Simplified Method for CT-Guided Stereotactic Brain Biopsy

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Over the past decade, CT-guided stereotactic brain biopsy, using several different stereotactic systems, has been shown to be a safe and accurate method for obtaining brain tissue for histological diagnosis.¹⁻⁹ Even with the improved sensitivity of neurodiagnostic procedures (such as MRI scanning), tissue diagnosis remains imperative for the appropriate management of all symptomatic brain lesions.^{3, 7, 9-11} Studies comparing therapy that would have been instituted based on preoperative clinical diagnosis versus confirmed histological diagnosis have shown that significant errors would have been made in up to 25% of the cases.¹²

Stereotactic biopsy is indicated for lesions that cannot be safely resected by open craniotomy or lesions that might be difficult to localize within the brain due to their small size.^{1, 11} Unfortunately, most stereotactic systems are expensive and complex in their operation.^{5, 13, 14} In this paper, a simple and rapid technique using a new and relatively inexpensive stereotactic system for CT-guided stereotactic biopsy is described.

Description of the Procedure

All patients were selected for stereotactic biopsy based on the need to obtain histologic diagnosis in order to institute appropriate therapy. Most patients undergoing stereotactic biopsy presented with a deep-seated brain lesion involving, for instance, the thalamus, pons, or deep subcortical

structures (Fig 1). The Pelorus Stereotactic Surgical System[®] was obtained from the Ohio Medical Instrument Company, Inc (Cincinnati, OH). The stereotactic procedure was performed as outlined in Table 1. Briefly, a trajectory to the target lesion was planned which did not traverse important vascular or neurologic structures. Typically, the entrance site was in the right frontal region. This area of the head was shaved, prepped, scrubbed sterilely, and draped. The Pelorus ring was then secured to the skull using cancellous bone screws, under local anesthesia (Fig 2A).

The patient was then transported to the CT scan suite. There, an intravenous contrast agent was administered (if needed) and the scan was performed with the guide rod in place (Fig 2B). After obtaining the CT scan, the patient was transported to the operating room and general anesthesia was induced. If needed, the procedure could also be performed under local anesthesia. While anesthesia was being induced, target coordinates were calculated and the depth of insertion determined using the phantom frame (Fig 2C). The target ball was then sterilized and placed within the Pelorus ring. A twist drill craniostomy was then performed and the lesion biopsied using a side-cutting aspiration needle (Fig 2D). The entire procedure usually required a total of 2 hours.

Illustrative Cases

Case 1

The patient was a 7-year-old male who presented with a 2-month history of seizures and altered mental status. CT scans were initially negative and the patient was started on anticonvulsant therapy. Follow-up CT scan showed a mass lesion to be present in the thalamus. Upon neurologic examination, no other abnormalities were found.

The patient was admitted to the hospital for stereotactic biopsy of the thalamic mass lesion.

Table 1. Stereotactic Brain Biopsy Procedure

1. Prepare head and attach base ring
2. Obtain CT scan and calculate coordinates
3. Set target ball on phantom frame
4. Perform craniostomy and biopsy lesion

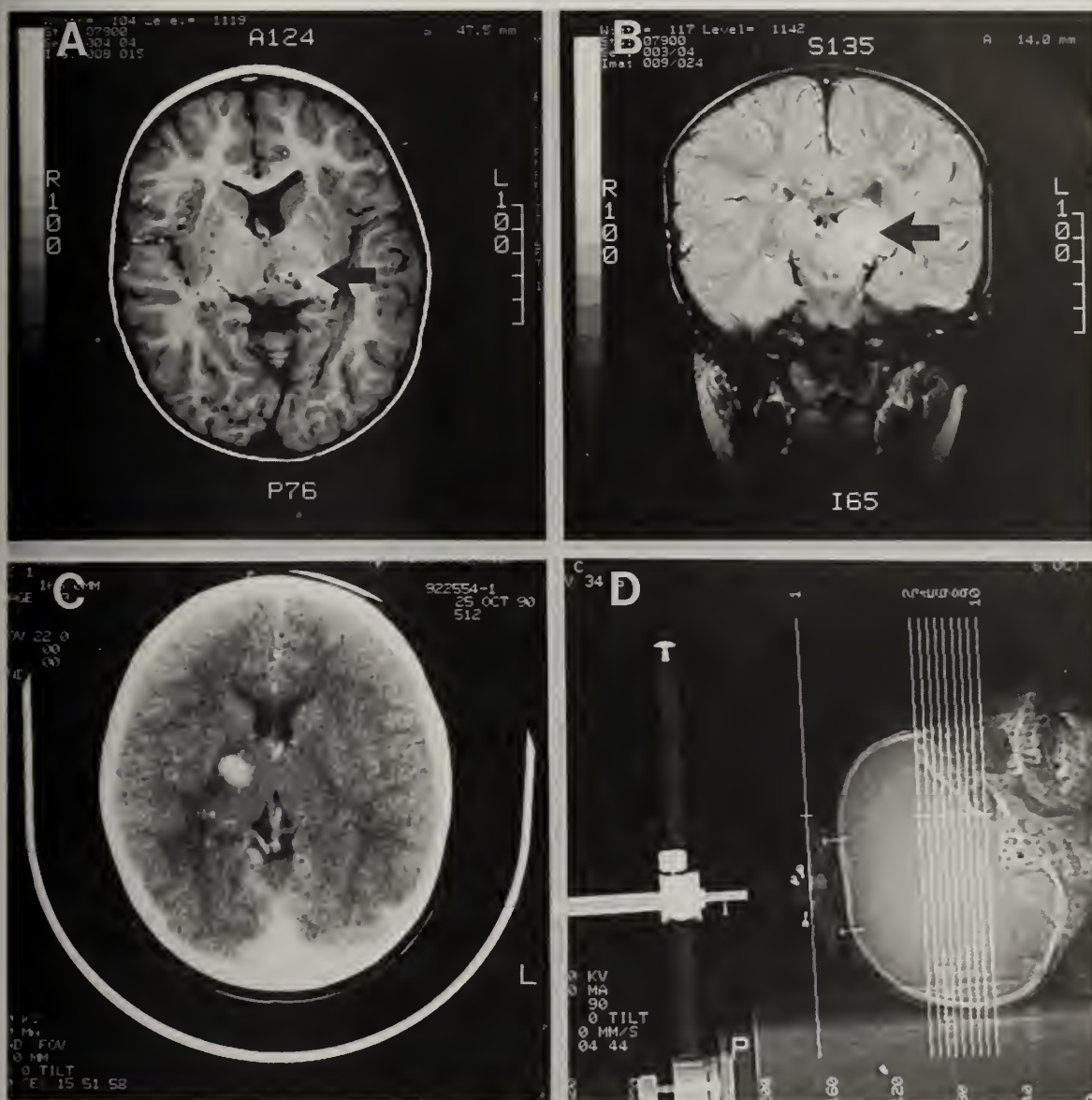


Fig 1 — Representative MRI or CT scans of patients who underwent stereotactic biopsy. Panel A: T1 weighted, axial view of lesion (arrow) in region of left thalamus, indicating the sensitivity of MRI for detecting small lesions. Panel B: Coronal view of same patient. Panel C: Contrast-enhanced CT scan of 1 cm lesion involving the right internal capsule (different patient). Stereotactic biopsy showed both of these lesions to be low grade astrocytomas. Panel D: Scout film, demonstrating sections obtained through the skull mount and target area.

This was performed under general anesthesia with the Pelorus System. Frozen section pathologic diagnosis revealed the lesion to be a well-differentiated astrocytoma. Postoperatively, the patient did well and was referred to pediatric oncology for consideration for chemotherapy. Ven-

triculoperitoneal shunt placement was also later required.

Case 2

The patient was a 55-year-old male who was admitted to the hospital after a generalized seizure.

CT-Guided Stereotactic Brain Biopsy

Table 2. Advantages of the Pelorus System

- | |
|-------------------------------------|
| 1. Relatively inexpensive |
| 2. Rapid and easy to perform |
| 3. Well-tolerated, even by children |
| 4. Greater access to the patient |

He complained of a headache and difficulty with the strength of his right arm and leg. Past medical history was positive for a history of smoking. Neurological examination revealed 4/5 strength of the right arm and leg, with increased deep tendon reflexes on that side, and a Babinski sign.

CT scan of the head showed three enhancing lesions with surrounding brain edema. Two lesions were located adjacent to the falx and one was located over the cerebral convexity in the posterior left frontal region. A biopsy of this last lesion was undertaken to obtain a tissue diagnosis, as no evidence of primary tumor was found after a thorough search, including CT scan of the chest. The patient elected to undergo the procedure under local anesthesia.

The patient tolerated the procedure very well and his strength improved postoperatively, most likely due to the administration of steroids. Pathologic diagnosis was positive for poorly-differentiated metastatic carcinoma, non-oat cell type. The patient was referred for radiation therapy and possible chemotherapy.

Case 3

The patient was a 6-year-old male with a 2-month history of double vision and difficulty of balance. Neurological examination revealed the presence of right sixth and seventh nerve palsies and difficulty with tandem walk. Head CT and MRI scan revealed the presence of a lesion diffusely involving the pons.

The patient was admitted to the hospital and underwent stereotactic biopsy of the pontine lesion under general anesthesia. Histologic diagnosis showed the lesion to be a well-differentiated astrocytoma. The patient did well postoperatively and was discharged on the second postoperative day. He was referred for consideration for radiation therapy and chemotherapy.

Discussion

Use of the Pelorus System for CT-guided stereotactic brain biopsy offers several advantages in com-

parison to other stereotactic systems, as outlined in Table 2. The Pelorus technique is rapid, relatively simple, and minimally threatening for patients, even those in the pediatric age group. The small size of the skull ring (Fig 2A) maximizes access to the head, which can be problematic with bulkier frames. All 25 patients that have undergone biopsy with the Pelorus System at the University of Louisville have tolerated the procedure well. No deterioration of neurologic function has resulted from stereotactic biopsy in these patients. Although complications (such as intracerebral hemorrhage) can still occur with stereotactic biopsy techniques, the method is believed to be less traumatic and more accurate than open brain biopsy.^{6,15}

The Pelorus System has been used for several other applications, including cyst and abscess aspiration, ventricular catheter placement, and some forms of brachytherapy. An additional arc system (not pictured here) allows use of the system for performing resection of tumors under stereotactic guidance. The Pelorus System has some disadvantages when compared to more sophisticated stereotactic equipment, but has proven to be a valuable and cost effective tool for performing CT-guided stereotactic biopsy at our institution.

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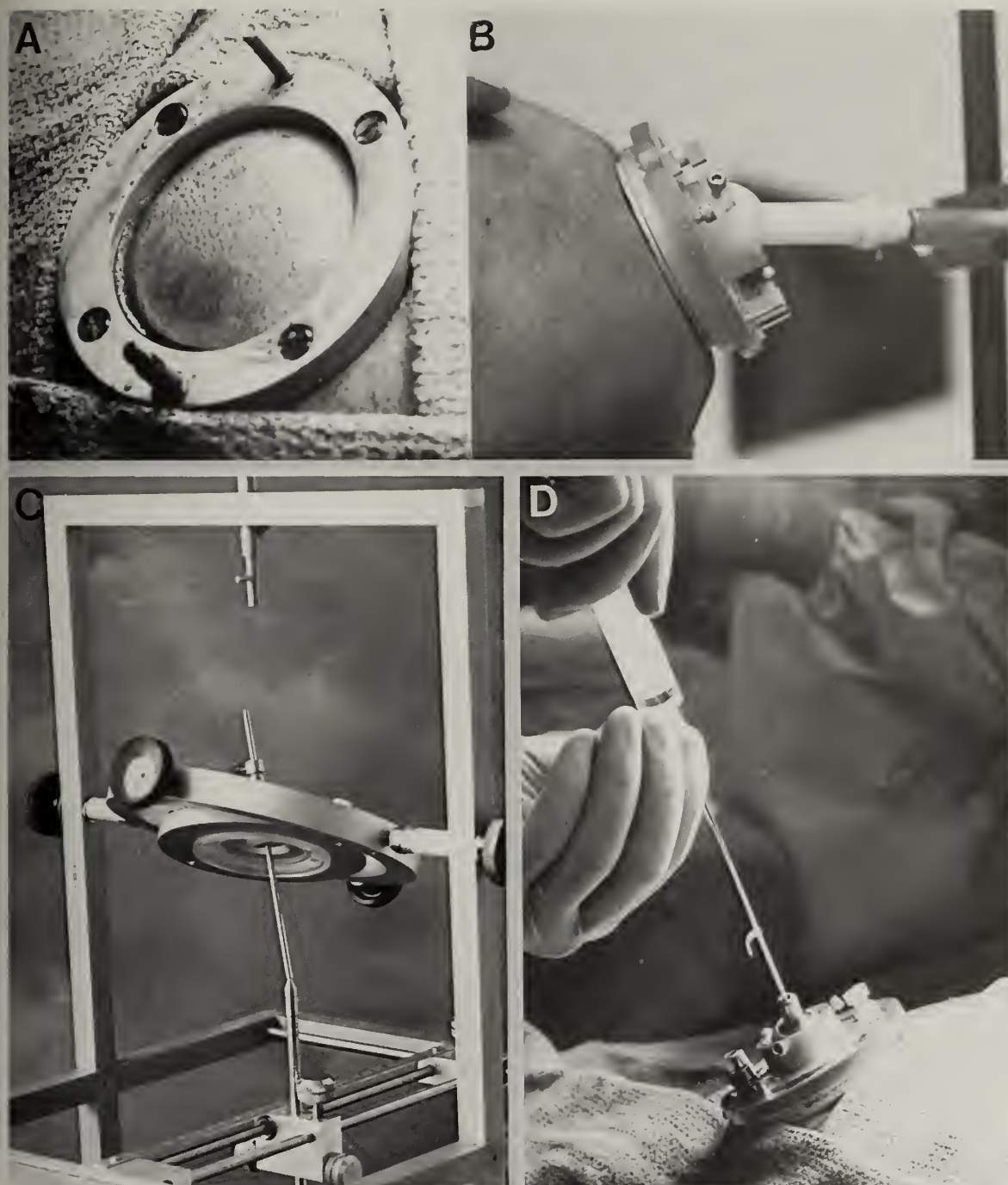


Fig 2 — Procedure for performing CT-guided stereotactic biopsy using the Pelorus Stereotactic Surgical SystemTM. Panel A: Skull ring in place, applied under local anesthesia. Panel B: Patient on CT gantry and attached to the table mount. Panel C: Phantom frame with target ball aimed at calculated target point. Panel D: Performance of biopsy, using side-cutting needle (local or general anesthesia).

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Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

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Drug Interactions—No interactions have been observed with theophylline, chlorazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric cryptic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belled rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumentary—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

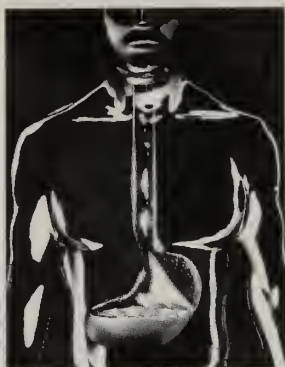
Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method. PV 2093 AMP [101591]

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral alpha-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

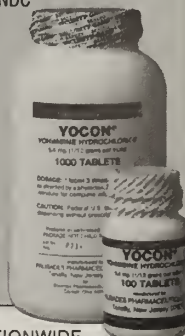
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

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From the Department of Surgery, University of Louisville School of Medicine, Louisville, KY 40292.

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Forty-nine patients have been referred to our institution for evaluation of orthotopic liver transplantation since our program started in 1990. Fourteen patients have been excluded for medical or psychosocial reasons. Eleven were accepted for future transplantations and are reevaluated every 3 months. Eight patients died while waiting for a suitable donor. Sixteen patients have undergone transplantations. One patient underwent transplantation a second time for refractory rejection of the first allograft. Five patients have died after liver transplantation. Eleven recipients are alive and well. Nine of the 11 have returned to normal activity.

centers. Considerable effort went into the organization and coordination of all the resources necessary to assure success of our program from the outset. The key resources that required special training and/or organizational restructuring included anesthesiology, the operating room staff, hospital and American Red Cross blood banks, nursing services, and laboratory services.

Patient Evaluation

Evaluation of potential recipients (Table 1) for a liver transplant is directed toward answering three questions:

1. Does the patient need a liver transplant?
2. Are there any contraindications to transplantation?
3. When should the procedure take place?

Three broad categories of disease account for the bulk of all liver transplants: (1) chronic progressive liver disease that is no longer responsive to conventional medical or surgical therapies, (2) fulminant hepatic failure, and (3) some primary hepatic malignancies that are limited to the liver but are not resectable by conventional surgical technique (Table 2).

In addition to having chronic liver disease amenable to transplantation, potential recipients must have another debilitating condition to warrant proceeding with a liver transplantation. These conditions include (1) portosystemic encephalopathy, (2) recurrent variceal hemorrhages, (3) intractable ascites, (4) intractable pruritus, (5) protein malnutrition, (6) progressive hepatic osteodystrophy, or (7) recurrent bouts of spontaneous bacterial peritonitis.

When fulminant hepatic failure is present, the cause of liver failure must be considered, as well as the length of the acute phase of the illness, the degree of coagulopathy, and other associated problems such as encephalopathy, when deciding whether or when to proceed with transplantation.

Introduction

Over the last 30 years, liver transplantation has become a viable option for the treatment of certain types of acute and chronic liver disease. Significant improvement in both the short- and long-term survival of recipients of liver transplants over the last 10 years has resulted in a dramatic increase in the number of liver transplants that are performed. Improved surgical technique and better postoperative care for the management of immunosuppression and other complications have been key to increased survival. As a result of improved survival, the indications for liver transplantation have been expanded. Currently, there are approximately 45 liver transplantation programs in the United States that perform more than 2500 liver transplants each year.

We began our liver transplantation program at Jewish Hospital in April 1990 and performed our first liver transplant in May 1990. Organization of all the resources necessary to start this service began in 1988. In today's medical environment, any new program such as a liver transplantation program must, from its inception, achieve as good a survival rate from the start as other preexisting



Patients with primary hepatic malignancies that are limited to the liver but are not resectable by standard surgical techniques should be evaluated and included for liver transplantation as soon as possible, provided that they are otherwise suitable candidates for the procedure. In these cases, consideration should be given to tumor type, histology, and the patient's general medical condition, when performing the evaluation.

Potential contraindications to liver transplantation are: (1) acquired immune deficiency syndrome or human immunodeficiency virus positivity, (2) malignancy outside of the liver, (3) active infection outside the hepatobiliary system, (4) willful noncompliance with previous medical therapy, and (5) advanced cardiac or pulmonary disease.

A Look at Patients Who Were Referred to Our Program

Forty-nine patients were referred to our center for evaluation for orthotopic liver transplantation since the program was started in 1990. Fourteen patients were excluded for medical or psychosocial reasons. Eleven patients were accepted for future transplantation but were deemed not in imminent need of a transplant. They are reevaluated every 3 months. Eight patients died while waiting for a liver transplant. Of these eight patients, two had fulminant hepatic failure and died within 48 hours of referral. Five had chronic liver disease but were referred too late in the course of their disease; multiple serious complications had already developed. Only one patient who died while waiting for a transplant had been in a stable condition. He was an outpatient who died of problems unrelated to his liver disease.

Sixteen patients have received liver transplants. Since one patient required retransplantation, we performed 17 liver transplants during the first year of the program. At the time of writing, 11 patients were alive and well 5 weeks to 17 months after transplantation. Nine of the 11 returned to normal activities (ie, normal activity for housewives, retirees, etc). One patient was at home progressing through a prolonged convalescence; the most recent recipient just went home. Data on the first 17 transplant recipients are listed in Table 3. The age range of our patients is 18 years to 66 years.

United Network of Organ Sharing

The level of illness of the recipient just prior to

Table 1. Liver Transplant Evaluation

A History, Physical, and a Review of any Biopsy Material is Undertaken

Laboratory Studies

- Hematologic and blood bank
- Blood chemistries
- Screening for infectious disease

Radiology

- Chest radiography
- Ultrasound study with Doppler examination of the portal vein, hepatic artery, and hepatic vein
- Angiogram of the abdominal vessels if indicated
- Computerized axial tomography scan of abdomen if indicated

Other

- Electrocardiogram
- Pulmonary function tests
- Cardiac catheterization as history indicates for:
 - Male over 50 years old
 - Female over 55 years old
- Doppler studies of carotid arteries if indicated
- Esophagogastroduodenoscopy if indicated
- Psychiatric evaluation
- Dental evaluation

Table 2. Indications for Liver Transplantation in Adults

- I. Irreversible chronic liver disease
 - A. Predominantly cholestatic disorders
 1. Primary biliary cirrhosis
 2. Sclerosing cholangitis
 - B. Predominantly hepatocellular disease
 1. Chronic virus-induced disease
 - a. Hepatitis B
 - b. Hepatitis C
 2. Chronic drug-induced disease
 3. Alcoholic liver disease
 4. Chronic autoimmune hepatitis
 5. Wilson's disease
 6. Congenital hepatic fibrosis
 - C. Budd-Chiari syndrome
- II. Fulminant Hepatic Failure
 - A. Viral hepatitis
 - B. Drug-induced hepatic failure
 - C. Wilson's disease
- III. Hepatic Malignancies (confined to the liver but not resectable)
 - A. Hepatocellular carcinoma
 - B. Cholangiocarcinoma
 - C. Carcinoid
 - D. Hemangiosarcoma
- IV. Inherited Metabolic Disorders
 - A. Alpha-1-antitrypsin disease
 - B. Hemochromatosis
 - C. Others

transplantation was defined by The United Network of Organ Sharing (UNOS). A status 1 patient is stable at home, status 2 is hospitalized, a status

Kentucky's First Liver Transplant Program

Table 3. Recipient Data

Disease	Patient Age	UNOS* Status	Outcome
Chronic Active Hepatitis C	50	1	Alive
	34	3	Alive
	66	1	Alive
Chronic Active Hepatitis B	52	1	Dead
	56	3	Dead
	39	1	Alive
	48	2	Alive
Primary Biliary Cirrhosis	60	3	Dead
	51	2	Alive
Hepatoma	60	1	Alive
	60	1	Alive
	27	1	Alive
Fulminant	18	4	Dead
	36	2	Alive
Alcohol-Induced	46	2	Alive
Rejection	50	4	Alive
Hemochromatosis	56	3	Dead

*United Network of Organ Sharing.

3 patient is in the intensive care unit, and status 4 means the patient requires life support measures such as ventilatory support and hemodialysis. Long-term survival appears to have no correlation to age at the time of transplantation, but as one might expect, it is directly related to severity of illness at the time of transplantation.

A review of UNOS data shows that the chance of a patient surviving one year varies by as much as 40% when the patients are stratified on the basis of severity of their illness at the time of transplantation.¹ Those patients who are in the best condition at time of transplantation have the best long-term outcome. The lesson that has been learned from this analysis is that those patients with identifiable chronic liver disease, which is progressing to end-stage disease, benefit greatly from early referral and transplantation and should not be kept waiting until they are in the terminal stages of their disease.

Operative Procedure

Removal of the diseased liver. The operative procedure can be divided into three distinct phases, which include dissection and removal of the native liver, the anhepatic phase, and the post-anhepatic phase. Extraction of the recipient's native liver can take anywhere from 1½ to 6 hours depending on previous biliary or upper abdominal surgery and the severity of portal hypertension. The liver is dissected from the surrounding tissue until it is connected only to its vascular structures. At that point, the portal vein and hepatic artery are clamped and severed, the inferior vena cava is clamped and severed both above and below the liver, and the diseased liver is removed.

Completing the transplantation. A venovenous bypass apparatus is used to shunt blood from the lower half of the body and the portal vein to the heart via cannulas in the femoral and portal veins, and a return cannula in the brachial vein (Fig 1). The anhepatic phase usually lasts about 70 minutes. The suprahepatic cava anastomosis, infrahepatic cava anastomosis, and the portal vein anastomosis are completed during this interval. The clamps are removed from these three vessels, and the transplanted liver is reperfused with portal blood. The stump of the hepatic artery is anastomosed end-to-end to the recipient's hepatic artery. After complete hemostasis has been achieved, the choledochocholedochostomy is performed (Fig 2A). This is done end-to-end over a T-tube, which exits from the recipient's native

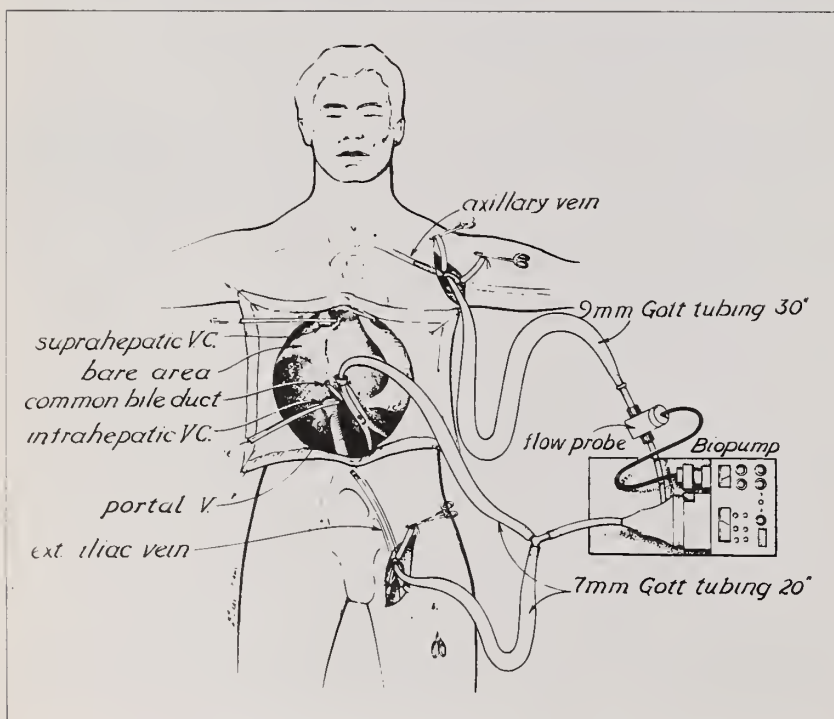


Fig 1 — Anhepatic stage of transplantation of the liver with cavoportal to axillary bypass circuit. (With permission from Griffiths BP, Shaw BW Jr, Hardesty RL, Iwatsuki S, Bahnson HT, Starzl TE. Veno-venous bypass without systemic anticoagulation for transplantation of the human liver. *Surg Gynecol Obstet* 1985;160:270.)

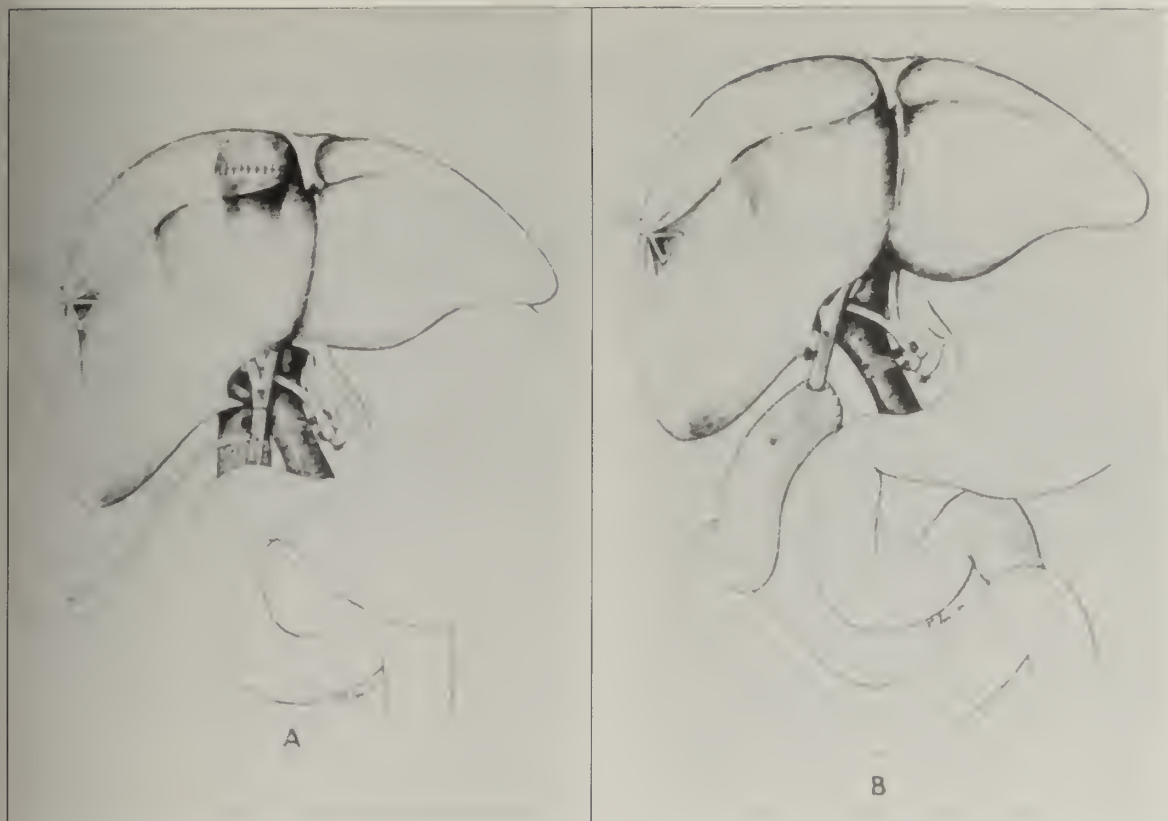


Fig 2 — Completed orthotopic liver transplantation. (A) Biliary tract reconstruction with choledochocholedochostomy. (B) Biliary tract reconstruction with choledochojejunostomy using a Roux limb. (With permission from Starzl TE, Shunzaburo I, Van Thiel DH, et al. Evolution of liver transplantation. Hepatology 1982;2:616.)

bile duct. If the recipient's native duct is unsuitable for use, a standard choledochojejunostomy is performed (Fig 2B).

Operating time and blood. The total operative time and amount of blood products used varies greatly. All of our patients, with the exception of those with cancer, have had severe portal hypertension, secondary hypersplenism, and prolonged prothrombin times prior to transplant. Some have had previous biliary tract surgery or portal systemic shunts. These factors influence the degree of difficulty encountered in extracting the old liver and the amount of blood products used (Table 4). The average number of packed red blood cell replacement units used has been 21 units, with a range of 7 units to 64 units and a median of 15 units. The average operative time was 10 hours, with a range of 6 to 13 hours. Neither length of operative time nor amount of blood products used had any correlation with ultimate outcome. There have been no operative deaths.

Disease Types

We have transplanted seven patients with end-stage liver disease due to chronic active hepatitis, four due to chronic active hepatitis B and three

to chronic active hepatitis C. Of the four patients with chronic active hepatitis B, three were surface antigen positive and one was surface antigen negative. Only one developed documented reinfection of the transplanted liver and subsequently died as a result of this infection 8 months after transplantation. The remaining three patients have had no evidence of disease recurrence. All were treated with a protocol that called for high doses of hepatitis B hyperimmune globulin, which was started during the anhepatic phase of the operation and continued indefinitely. Patients who are positive for hepatitis B surface antigen but who are negative for E antigen and hepatitis B viral DNA appear to have a good chance of

Table 4. Blood Product Usage (units) for 17 Liver Transplant Recipients.

	Mean	Median	Range (units)
Packed blood red cells	21	15	7 to 64
Fresh frozen plasma	28	18	10 to 93
Platelets	20	20	0 to 60

Kentucky's First Liver Transplant Program

survival without reinfection, provided that immunoglobulin prophylaxis is administered indefinitely after transplantation.

The three patients who received transplants as a result of chronic active hepatitis C have had no evidence of disease recurrence in the new liver. The experience at most centers is that those patients with chronic active hepatitis C have a very low incidence of reinfection of the graft (personal communication).

Three recipients had primary hepatic malignancies. Overall, results in these cases have been very poor. Many patients develop a malignancy in the new liver, indicating a failure to eradicate the original tumor. Consequently, our policy has been to approach these patients cautiously. We only accept patients who have hepatomas that histologically or clinically appear not to be aggressive. All tumors have been limited to the liver, as determined by the pretransplantation evaluation. One of these patients had undergone a resection of his hepatoma with positive margins almost 3 years before transplantation. There was no evidence of tumor outside the liver at the time of original surgery. The hepatoma remained confined to the liver during the intervening 3 years, and at the time of transplantation no tumor was found outside of the liver. The second patient had prolonged exposure to vinyl chloride years before, with subsequent development of cirrhosis. He had been followed for several years for what was thought to be a biopsy-proven hepatic adenoma. Serial biopsies demonstrated what was thought to be malignant changes. He also had no evidence of extrahepatic tumor at the time of transplantation. The third patient had a fibrolamellar variant of hepatocellular carcinoma. He underwent a staging laparoscopy with node sampling (all negative) before liver transplantation. He was entered into a protocol that called for pretransplant high-dose intraarterial chemotherapy followed by posttransplant chemotherapy. In the future, all subsequent hepatoma patients will be so treated.

Complications

Operative complications have been minimal. One patient required incidental splenectomy. No patient required reexploration for postoperative hemorrhage or postoperative infection.

There were three biliary complications, two of which required reoperation. Bile duct reconstruction included choledochocholedochostomy

in all cases but not in the instance of the retransplantation. Routinely, we leave T-tubes in place for 5 to 6 months in all patients, and they are clamped as soon as the bilirubin is less than 5 mg%. This provides prolonged stenting of an anastomosis in those patients who are slow to heal, as well as providing easy access to the duct if liver function deteriorates.

One patient developed a leak and stricture at the choledochocholedochostomy 7 weeks after the transplantation. This required conversion of the anastomosis to a choledochojejunostomy. A second patient developed a bile leak around the exit site of the long arm of the T-tube. This was managed by suturing the exit site more securely. A third biliary tract complication was related to sludge accumulation in the common bile duct 2 months after transplantation. This problem was resolved with irrigation of the biliary tree through the T-tube.

Most of the complications we noted were due to infections. We have identified no vascular complications as yet, even though several of the recipients had multiple separate hepatic arteries that required complicated reconstruction. Most centers report a 5% to 10% incidence of thrombosis of the hepatic artery, a devastating complication that usually requires retransplantation.² Also no primary nonfunctions of the allograft occurred in our series. Primary nonfunction is reported to occur in about 1 in 20 transplants, and, in these instances the transplanted liver never functions.³

Two patients developed pancreatitis; one died and the other had a mild case. The majority of the complications we noted were caused by either cytomegalovirus infections or bacterial sepsis, or both. In the beginning, *Pseudomonas* infections were a problem, but after putting all patients on a 2-week postoperative course of norfloxacin (Noroxin®) by mouth, there were no more *Pseudomonas* infections.

Nearly all patients develop some degree of renal dysfunction after liver transplantation, and this was the case in our small series.⁴ Five patients required hemodialysis before transplantation because of hepatorenal syndrome. Only one of these patients and two others required long-term hemodialysis after transplantation.

Six patients developed serious cytomegalovirus infections after transplantation. Two have subsequently died. Five were disseminated infections and one was cytomegalovirus hepatitis.

Five patients died after receiving their liver transplant. Four were UNOS status 3 or status 4 at

the time of transplantation. One patient died 2 weeks after transplantation from necrotizing pancreatitis and erosion of the splenic artery. Two patients died from an uncontrolled cytomegalovirus infection and bacterial sepsis after 3 months. A fourth patient developed a progressive neurologic deficit and continuous seizures which could not be controlled. One patient died of recurrent hepatitis B in the allograft 7 months after receiving his transplant. He had been free of disease for the first 6 months but rapidly deteriorated when his new liver became infected.

Conclusion

We have had modest success in the first year of our liver transplantation program. The survival rate in our series equals that of others. Happily, most of our patients have not just been returned

to good health but were able to resume active, productive lives.

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Libraries

We physicians have books — medical, historical, social, fiction, non-fiction, etc. The list goes on and on. Some books sit on our shelves, reminding us of our studies. Pages are bent and soiled by the years, and old ink is fading in intensity. Some are so familiar their covers instantly remind us of years studying, of particular subjects or professors. Libraries contain many such memories, for the thousands who have passed the shelves and taken what they need. Each library nurtures some group of people, most of whom owe a part of their progress to this experience.

Jefferson county voters have rejected the tax to fund the Jefferson County Public Library. Some were sated with taxation, and rejected any effort to feed the bureaucracy. Others felt that government was capable, if not yet committed to infusing money and direction to the library. Unfortunately, some voters denied the very need for a viable library, considering the doings in such places as alien and certainly not in their best interest. But physicians are learners; they are perpetual students. Examined by patient and government, they of necessity, if not of joy, must keep the books by their side. Not only our own

self-interest is served by a better library, but the patients and their educational enrichment would greatly enhance the happenings of the medical encounter.

“Each library nurtures some group of people, most of whom owe a part of their progress to this experience.”

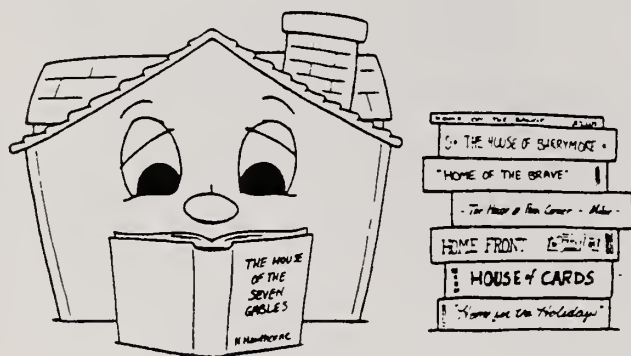
Leadership is born of opportunism, of vision, and of timing. Such a moment is here, in the forecourt. We need to demonstrate that the need of a vibrant and active library is paramount, and certainly in the public's best interest. What have we to lose? *Generations of productive people without the appropriate intellectual skills to cover the territory.*

Stephen Z. Smith, MD

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Health and Safety Tip From the American Medical Association

MARKERS LISTED TO IDENTIFY ALCOHOLICS

How can you tell that a regular, heavy drinker has crossed over the line and become an alcoholic, who no longer can control his or her drinking?

The American Medical Association in its Manual on Alcoholism points to some markers to help identify the alcoholic.

1. Increasing consumption of alcohol, with frequent, perhaps unintended, episodes of intoxication.
2. Drinking to handle problems or relieve symptoms.
3. Obvious preoccupation with alcohol and the frequent need to have a drink.
4. Surreptitious drinking or gulping of drinks.
5. Tendency toward making alibis and weak excuses for drinking.
6. Refusal to concede what is obviously excessive consumption and expressing annoyance when the subject is mentioned.
7. Frequent absenteeism from the job, especially following weekends and holidays.
8. Repeated changes in jobs, particularly if to successively lower levels, or employment in a capacity beneath ability, education, and background.
9. Shabby appearance, poor hygiene, and behavior and social adjustment inconsistent with previous levels or expectations.
10. Persistent vague physical complaints without apparent cause, particularly insomnia, stomach upsets, headaches, loss of appetite.
11. Multiple contacts with the health care system with disorders that are alcohol caused or related.
12. Persistent marital and family problems, perhaps with multiple marriages.
13. History of arrests for drunkenness or drunken driving.

*Submitted by the KMA
Impaired Physicians Committee*

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Will Physicians and Legislators Work Together in 1992?

“It takes less time to help legislators pass good laws than to get bad ones reversed.”

It is again time for the General Assembly of Kentucky to meet. Important issues will be discussed, decided, and many will become laws. Many bills will be presented that will impact public health and medical practices in the Commonwealth. So far, I have presented facts; at question is when physicians and their spouses will become involved. At the beginning of the session by providing legislators with medical information and expert opinion, so they can make wise choices? By contacting legislators so these elected officials can know the wishes of their constituents? Or will we ignore the whole process until we must deal as best we can with what laws are passed?

We in the Auxiliary to the Kentucky Medical Association chose to make our best effort to let our opinions be known now. To be better informed on the position of the KMA on proposed legislation, there is now an AKMA member sitting on the KMA Legislative Committee. The AKMA will have its key contact phone bank in place for legislative emergencies. The Day at the Capitol will be February 19. We will meet at 10 AM in the House Chambers, and we are pleased that Speaker of the House Don Blandford will speak to us. All physi-

cians as well as all auxiliaries are invited to attend. We hope for a large turnout in support of medicine.

When my husband's grandfather started practice in the early 1900s, there were few laws dealing with medicine. When his father came to Kentucky in the early 1950s, there was self-regulation in the medical community, medical licenses, national boards, etc, but still few federal and state laws dealing with the day-to-day practice of patient care. You know what our spouses now face in their practice. As you glance at the *AMA NEWS* almost half of its articles deal with political and legal issues. Just half are about medicine. It grows more complex each year. Consider the "Right to Die" proposal Washington voters went to the polls to decide in November, HIV testing for health care professionals, RBRVS, or national health.

There was a patient who watched a melanoma grow on his face for 2 years. He finally went to a physician when it began to hurt him. After waiting all that time, it was too late. It takes less time to help legislators pass good laws than to get bad ones reversed.

Diana Miller Moore
AKMA Legislative Chairman



Lady Killer

Among many young women, smoking is viewed as stylish.

It is not. Smoking is deadly.

If you smoke, please consider stopping. For help, information and support,
please contact your local American Cancer Society.



Physician-owned Laboratories

TO THE EDITOR: The new Health Care Financing Administration (HCFA) regulations regarding physician-owned laboratories are for all of us. It is a new law, fostered by Representative Pete Stark (D-CA). It is clearly going to have far reaching and profound results. It is going to effect the pocketbooks of those physicians who have financial interests in clinical laboratories. It is going to disrupt patterns of practice. It is going to inconvenience patients and slow the normal flow of practice. It may end up enriching the major clinical laboratories. It does not seem to be aimed at quality control and may even lower the quality of laboratories.

The avowed purpose of this bill is to control the "unnecessary" ordering of lab tests. The theory being that if you own a laboratory you will order more tests. **Just to make money?**

A large number of surveys have been mailed. The survey must, under threat of large fines, be answered. If you find it cumbersome, one of three ladies in the Medicare Office will walk you through the questions: Jennifer Dawson (606-281-5842); Sara Mundy (606-281-5830); or Sandra Roach (606-281-5849).

Those laboratories in offices which do the most basic and simple tests will, it seems, escape control. The efficient labs controlled and owned by physicians who do the majority of tests quickly with high quality are most apt to be in trouble because of the perceived conflict of interest.

Details are not clear and won't

be until the results of the surveys are analyzed.

There is already a law on the books. HCFA must carry out the provisions to the best of its ability. As usual, there is a listing of penalties that may be invoked (ie, a threat). The required paragraphs follow:

Section 1877 of the Social Security Act requires that we collect financial ownership information from all entities that furnish Medicare covered clinical laboratory services. Any person who is required to provide the requested information but who fails to do so is subject to a civil money penalty.

Because of concerns expressed by disclosing entities furnishing clinical laboratory services that they may require more time to obtain information necessary to complete the financial ownership survey, the Health Care Financing Administration extended the deadline for return of the surveys to us until November 1, 1991. No civil money penalties will be pursued against entities who returned completed surveys to us by November 1, 1991.

We appreciate your continuing assistance in this initiative and encourage you to notify your membership of this information promptly. If you have any questions or need additional information contact Jennifer Dawson, Medicare B, (606) 281-5842.

J. B. Holloway, MD

FEBRUARY

23-28 — 23rd Family Medicine Review, Session I; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

MARCH

6-7 — 35th Annual Postgraduate Ophthalmology Symposium; Diabetes Mellitus: Ophthalmic Perspectives; Hyatt on Capitol Square, Columbus, OH. Contact: 800/492-4445.

21 — Kentucky Thoracic Society 37th Annual Scientific Conference on Pulmonary Disease (Mechanical Ventilation), Lexington, KY. Contact: 1/800/366-LUNG.

APRIL

10-12 — Sports Medicine for Physicians; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161,

24-25 — Contemporary Pediatrics for the Practicing Physician; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine

Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

MAY

1-2 — Annual Meeting, The Virginia Society of Otolaryngology-HNS; Boar's Head Inn, Charlottesville, VA. Contact: Donna Scott, 4205 Dover Rd, Richmond, VA 23221; 804/353-2721.

8-9 — Diabetes, Lipids and Obesity: Critical Assessment of Risk Factors; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

17-22 — 23rd Family Medicine Review, Session II; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

JUNE

1-3 — 60th Assembly of the Southeastern Surgical Congress, Atlanta, GA. Presentations and posters should be submitted by November 15, 1991. Contact: Roger Sherman, MD, Secretary Director of the Southeastern Surgical Congress, 69 Butler St Southeast, #314, Atlanta, GA 30303.

AUGUST

8-14 — 11th Annual Scientific Meeting and Exhibition of the Society of Magnetic Resonance in Medicine; Berlin, Germany. Contact: SMRM, 1918 University Avenue, Suite 3C, Berkeley, CA 94704; 510/841-1899; FAX 510/841-2340.

SEPTEMBER

3-5 — Perinatal Medicine; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

25-26 — 5th Annual Rehabilitation Management for the Primary Care Physician; Radisson Plaza Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

OCTOBER

25-30 — 23rd Family Medicine Review, Session III; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.



Journal Wins First Place Award

The *Journal of the Kentucky Medical Association* received the first place award for Excellence of Design and Printing in the 1991 journal competition of the American Medical Writers Association Conference recently held in Toronto.

The *Journal* submitted July and August 1991 issues for judging. Professor Byron Scott, University of Missouri Department of Journalism, with the assistance of magazine design professor Jan Colbert, judged the entries. Professor Scott's comments included "the magazine has a clean, modern design . . . presents a lot of text material in a very readable fashion . . . consistently designed and edited,

with attention to detail . . . obvious that an excellent job is done by your staff in supervising the printing of the publication."

Part of a program to encourage superior medical editing and writing, the AMWA awards attract entries from all over the country.

1991 was a banner year for the *Journal*. Never having received an award in its history, the KMA publication was recipient of two awards during the year. In March 1991, it received an Honorable Mention Award in the annual Sandoz Pharmaceuticals competition.

Editor A. Evan Overstreet, MD, has a right to be proud of his association's flagship publication. *KMA*

PEOPLE

Two KMA members will be among the nine distinguished U of L alumni to be honored this spring as 1992 Alumni Fellows. Those members and the units nominating them are:

Division of Allied Health —

Thomas Demaree Cummins, MD, of Louisville, a reconstructive and plastic surgeon on staff at various Louisville hospitals.

School of Medicine — **George W. Pedigo, MD**, of Louisville, an internist and emeritus clinical professor of medicine and member of the Board of Overseers.

Devinder S. Mangat, MD, from Cincinnati, OH, was voted treasurer-elect of the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS) at elections held during the Academy's Annual Meeting in Kansas City, MO. Dr Mangat presently maintains a facial plastic and reconstructive surgery practice in both Cincinnati and Lexington.

John Spratt, MD, U of L Department of Surgery, received a certificate of achievement from the Commission on Cancer of the American College of Surgeons for work as state chairman of cancer programs in Kentucky from 1983 through 1989. He recently served as guest faculty for the Advanced Trauma Life Support Course at Brooke Army Medical Center in Ft. Sam Houston, Texas.

H. Mac Vandiviere, MD, a Lexington pediatrician, was reelected President of the American Lung Association of Kentucky at the association's recent annual meeting in Lexington.

Alvin Martin, MD, a pathologist, represented U of L through a poster session at a National Society for Histotechnology convention in

Orlando, FL. Dr Martin was author of the poster, "Immunohistochemical Detection of Estrogen and Progesterone Receptor in Cystosarcoma Phylloides Tumor of the Breast."

Kenneth P. Crawford, MD, a Louisville pediatrician with the Kentucky Commission for Handicapped Children, has been appointed to the board of the Spina Bifida Association of Kentucky.

Richard Greathouse, MD, Jefferson County coroner and pediatrician, has been reappointed to the Kentucky Sudden Infant Death Syndrome Advisory Committee.

Robert F. Sexton, MD, a neurosurgeon, has been elected to the board of Saints Mary and Elizabeth Hospital in Louisville.

Roger J. Shott, MD, an Anchorage pediatrician, has been appointed to the Kentucky Perinatal Advisory Committee.

Maurice E. John, MD, a Jeffersonville, Indiana ophthalmologist, has been awarded board certification in the sub-specialty field of cataract implant surgery from the American Board of Eye Surgery.

Mellayne R. Myers, MD, recently returned from Desert Shield/Storm. He is currently an industrial/occupational physician with Toyota Manufacturing USA following a 13-year career in emergency medicine.

Paul J. Grumley, MD, an internal medicine specialist practicing in Paducah, has been elected to fellowship in the American College of Physicians.

Patricia Quinby, MD, U of L Department of Family Practice, recently presented a paper on medical education at the Society of

Teachers of Family Medicine northeast regional meeting in Cincinnati. She also participated in a recent production of "Health-Cast Line" on WAVE answering viewers' questions for "the family doctor."

Joseph E. Kutz, MD, Louisville surgeon, has been elected president of the Rotary Club of Louisville and chair of the executive committee of the Leadership Louisville Foundation Board of Directors.

UPDATES

New Program Will Help Recruit Health Professionals To Underserved Areas of Kentucky

A new federal grant which links students who need scholarships with rural communities in need of health professionals has been awarded to a consortium of state, university and primary care practitioners. The University of Kentucky Center for Rural Health and Physician Placement Service will administer the \$45,000 grant for a consortium which includes the Kentucky Department for Human Services, the Kentucky Primary Medical Care Association, the University of Louisville Physician Placement Service, and the Kentucky Rural Medical Scholarship Program of the Kentucky Medical Association.

The grant establishes the Kentucky Rural Community Scholarship Program to recruit nurse midwives, nurse practitioners, physician assistants and primary care physicians into underserved rural communities. Communities in need of these health professionals will contribute to the cost of the scholarship. In return, scholarship recipients will spend a predetermined amount of time practicing in a community after completing their program of study. The time

commitment will vary according to the needs of the participating communities and the types of scholarships awarded.

"This small but significant grant has the potential to make permanent improvements in the availability of primary health care professionals to high-need counties across Kentucky," said **Dr Carlos Hernandez**, Commissioner of the Kentucky Cabinet for Human Resources. He said the consortium hopes that the grant will be renewed beyond the initial one-year award.

Forty percent of the total cost of the program will be met with federal funds and 35% will be contributed by participating rural communities. The remaining 25% will be provided by consortium members.

The Rural Community Scholarship Program expects to begin awarding scholarships in the spring of 1992.

UK Awarded Interdisciplinary Rural Health Grant

An interdisciplinary team at the University of Kentucky has been awarded a \$586,739 federal grant involving students, faculty and rural health care professionals. The 3-year grant to improve rural health care for older adults involves five colleges: Allied Health Professions, Medicine, Nursing, Pharmacy and Social Work. Sponsoring organizations are the UK College of Allied Health Professions, the UK Sanders-Brown Center on Aging, and the St. Claire Medical Center in Morehead.

Medicine, nursing, pharmacy, physician assistant and social work students will work with health care professionals in primary care centers in rural northeast Kentucky. The project will assist students with their clinical training in geriatrics and also will provide faculty development and continuing education activities for rural health care professionals.

Over the life of the 3-year grant, it is projected that 120 students will complete a 4-week clinical rotation. One hundred fifty rural health care professionals will participate in continuing education programs and 45 faculty members will be involved in professional development activities.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Barren

Melissa K. Walton-Shirley, MD — IM
1004 Glenview Dr, Glasgow 42141
1986, U of Louisville

Boyd

Charles J. Dietzen, MD — PMR
2211 Montgomery Ave, Ashland 41101
1987, Indiana U

Calloway

Robert M. Korolevich, MD — FP
300 S 8th St #204, Murray 42071
1988, East Virginia Medical School

Clay

Jack S. Lucas, MD — FP
301 Memorial Dr, Manchester 40962
1958, Loma Linda U

Fayette

Berry A. Campbell, MD — OBG
UKMC — Dept OB/GYN,
Lexington 40536

1985, Medical U of South Carolina
Lee B. Daniel, MD — PS
1221 S Broadway, Lexington 40504
1984, Vanderbilt U

Alan M. Gardner, MD — AN
UKMC — Dept Anesthesiology,
Lexington 40536
1980, U of Michigan

Nicholas S. Hellmann, MD — ID
1780 Nicholasville Rd #603,
Lexington 40503
1982, U of Kentucky

Arnold S. Koriakin, DO — R
1221 S Broadway, Lexington 40504
1979, Philadelphia Col of Osteopathic
Med

Kenneth L. Parish, MD — S
1221 S Broadway, Lexington 40504
1985, Johns Hopkins U

James H. Patterson, Jr MD — OPH
1701 Nicholasville Rd,
Lexington 40503

1964, Tulane
Michael A. Rie, MD — AN
UKMC — N-219, Lexington 40536

1966, Harvard
Jeremiah Suhl, MD — IM
1221 S Broadway, Lexington 40504
1978, U of California, Los Angeles

Victor L. Zirilli, MD — R
1221 S Broadway, Lexington 40504
1981, U of Texas, Galveston

Floyd

Virginia A. de Guzman, MD — GP
Drawer D, Martin 41649
1957, U of Santo Thomas

Greenup

Eugene R. DeGiorgio, Jr, MD — R
930 Brenda Sue Dr, Flatwoods 41139
1981, Loyola U

James H. Martin, Jr, MD — S
103 St. Christopher Dr, Ashland 41101
1986, Howard U

Grayson

Earle Travis, Jr, DO — FP
507 Morgantown St, Caneyville 42721
1986, U of New England

Hardin

Michael J. Millette, MD — GP
610 Debra Ln, Elizabethtown 42701
1985, U of Illinois

Knox

Bruce R. Jung, MD — FP
P O Box 1150, Barbourville 40906
1988, U of Chicago

Madison

- Michael W. Cole, DO** — FP
789 Eastern Bypass #27,
Richmond 40475
1986, Southeastern College of
Osteopathic Medicine, N Miami Beach
William F. Sweeney, MD — OBG
Prof Bldg, Lancaster Rd,
Richmond 40475
1974, U of Guadalajara

Northern Kentucky

- Mark A. Cepela, MD** —PS
20 Medical Village Dr,
Edgewood 41017
1984, U of Michigan
Daniel J. Connor, MD — S
20 Medical Village Dr #132,
Edgewood 41017
1979, Creighton U
Kenneth A. Glavan, MD — S
1058 Arden Dr, Villa Hills 41017
1986, Medical College of Ohio
Douglas A. Goderwis, MD — IM
7621 Dixie Hwy, Florence 41042
1987, U of Louisville
Donald L. Mitts, MD — TS
20 Medical Village Dr #208,
Edgewood 41017
1971, U of Kentucky
Steven P. Noll, DO — AN
3041 Edgemar Dr #B,
Edgewood 41017
1987, Chicago College of Osteopathy
T. Greg Sommerkamp, MD — ORS
20 Medical Village Dr #177,
Edgewood 41017
1985, U of Kentucky
Michael P. Spadafora, MD — EM
234 Goodman St, Cincinnati 45267
1984, U of Cincinnati
Beverly G. Wheeler, MD — P
1139 Beverly Hill Dr, Cincinnati 45208
1978, Medical College of Virginia

Perry

- Jayalakshmi Pampati, MD** — RHU
200 Medical Center Dr, Hazard 41701
1981, Madras U

Pike

- Lela C. Maynard, MD** — IM
29 Kinnikinnick Ln, Pikeville 41501
1988, U of Louisville

Pulaski

- Ramon H. Gonzalez, MD** — OBG
347 Bogle St, Somerset 42501
1974, U of Puerto Rico
Zeev Zusman, MD — P
3904 Hickory Hill Dr, Somerset 42501
1981, Israel Inst of Technology

Warren

- James F. Beattie, Jr, MD** — PTH
P O Box 687, Bowling Green 42104
1976, U of Tennessee
Diana K. Cavanah, MD — A
2828 Edwards Dr,
Bowling Green 42101
1986, U of Missouri
Phillip J. Singer, MD — ORS
261 Mooresborough Ln, Bowling
Green 42103
1986, U of Louisville
David M. Smith, MD — AN
1228 Ashley Cir, Bowling Green 42102
1987, U of Kentucky

Whitley

- David Wrede, MD** — EM
409 Jackson St, Berea 40403
1980, U of Kentucky

In-Training**Jefferson**

- Harold G. Stringer, MD** — IM

St. Elizabeth's —

- Jeffrey J. Blau, MD** — FP
Michael A. Boyd, MD — FP
Francis P. Kohrs, MD — FP
Todd Richardson, MD — FP
Samuel C. Wang, MD — FP

DEATHS

George H. Rodman, MD
Greenville
1916-1991

George H. Rodman, MD, a retired surgeon, died October 2, 1991. Dr Rodman was a 1940 graduate of St. Louis University School of Medicine and a life member of KMA.

John A. Bishop, MD
Louisville
1908-1991

John A. Bishop, MD, a retired general practitioner, died October 23, 1991. Dr Bishop was a 1933 graduate of the University of Louisville School of Medicine and a life member of KMA.

George L. Foster, MD
Lexington
1935-1991

George L. Foster, MD, a retired internist, died November 17, 1991. Dr Foster graduated from the University of Cincinnati School of Medicine in 1961 and was a life member of KMA.

Dwight M. Kuhns, MD
Louisville
1902-1991

Dwight M. Kuhns, MD, a retired pathologist, died November 18, 1991. A 1929 graduate of the University of Louisville School of Medicine, Dr Kuhns was a life member of KMA.

Louis Mitzlaff, MD
Louisville
1913-1991

Louis Mitzlaff, MD, a retired internist, died November 26, 1991. Dr Mitzlaff was a 1937 graduate of the University of Louisville School of Medicine and a life member of KMA.

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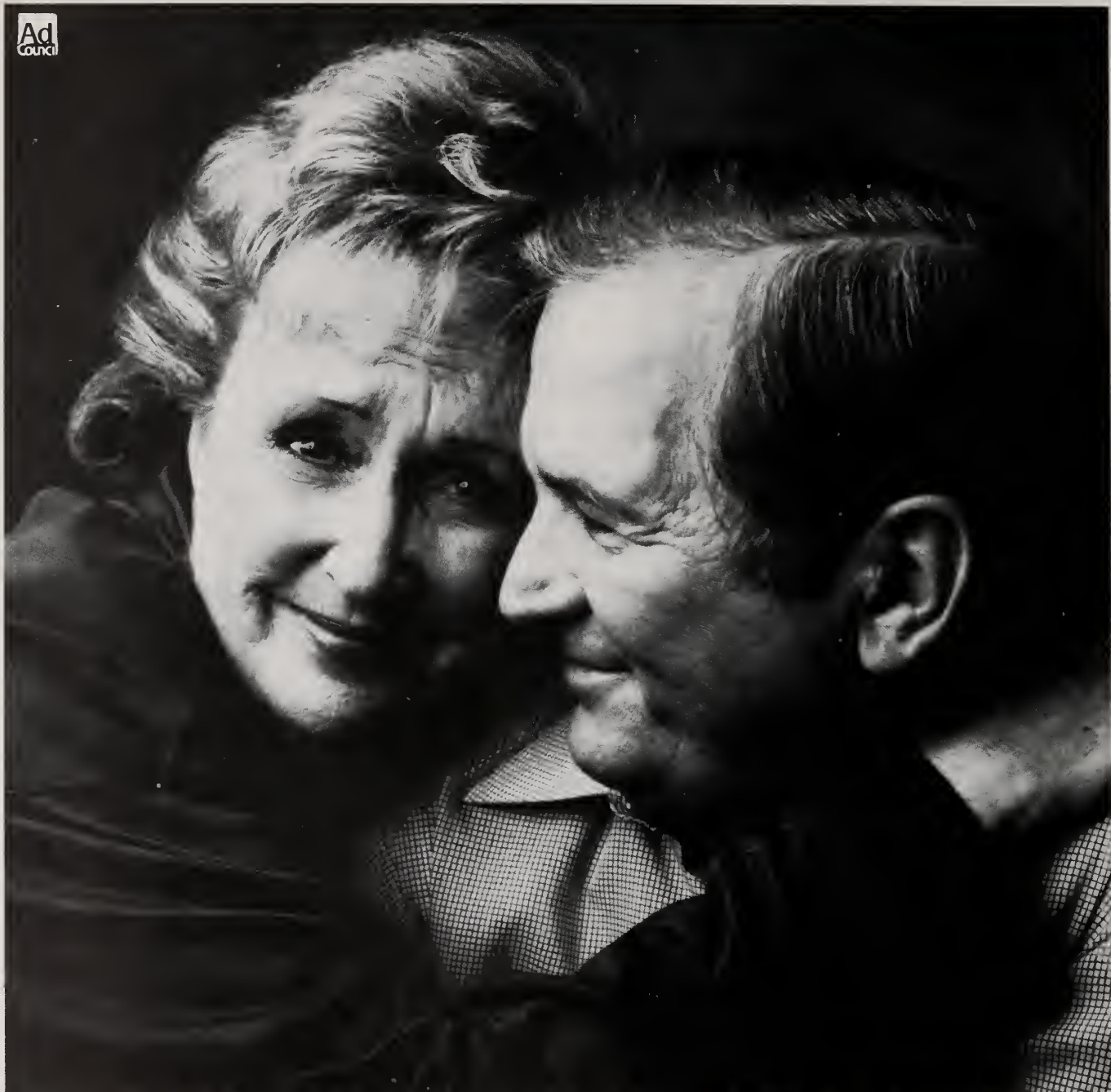
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State Reformatory, LaGrange, KY 40032, 502/222-9622.

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BRIEF SUMMARY

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Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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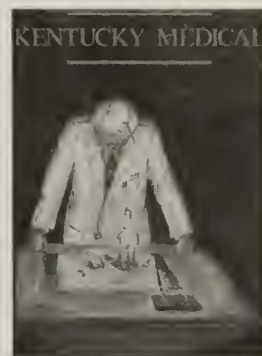


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COVER: Design by Lee Wade, Louisville, KY, introduces a special article on impaired physicians. See page 62.

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Violence: A Major Public Health Problem

Violence is one of the major public issues facing the medical community today, and its consequences are felt by many in all segments of our society. This is an important issue for all physicians despite the type of medical practice or location of practice and one that deserves special attention.

According to the Centers for Disease Control, homicide and suicide are among the foremost causes of premature death in the United States. Between four to six million women are victims of violence yearly and between two to four million women are battered by their spouses or male partners. Studies now document that women in the United States are more likely to be assaulted and injured, raped or killed by a current or ex-male partner than by all other types of assailants combined. Annually in the United States more than two million cases of child abuse and neglect are reported. Most sexual abuse of children is perpetrated by a family member. It is also recognized that as much as 3% of the elderly population is abused each year.

In Kentucky in 1991, 4128 cases of elder abuse were reported to the state including all types of abuse — neglect by caregiver, spouse abuse, abuse by another adult, and exploitation. In Kentucky in 1991, 20,000 reports of spouse abuse were

made known to the state, and last year 53 homicides or suicides were determined to be the result of domestic violence. In our state in 1991 there were 32,318 reports of child abuse involving 51,465 children, and 42% of these reports were substantiated. Family violence and violence against women have reached epidemic proportions. How many situations exist where there is no reporting? As physicians, we find these statistics frightening and

therefore a cause of great concern.

Former US Surgeon General C. Everett Koop, MD, has stated that Americans have "mistakenly agreed that violence was the exclusive province of the police, the courts, and the penal system." Dr Antonia Novello, Surgeon General of the United States, reported at the 1990 AMA National Leadership Conference in reference to violence against women that "the medical community has yet to *consistently* identify the affected women as victims and extend treatment beyond the physical manifestation of an abusive relationship."

Physicians much of the time are ill prepared to recognize, treat, and prevent this form of *public health problem*. The AMA has included this issue as one of its major agenda items for the future, and their efforts are to be applauded. This is not only a national issue but also one of local community and state importance and an issue on which we as Kentucky physicians must educate ourselves and our communities.

Unlike the child abuse movement where physicians have taken a leading role, physicians have had minimal involvement in addressing other forms of family violence such as sexual abuse, domestic violence, and elder abuse. A project funded by the National Institute of Mental Health

“Dr Antonia Novello, Surgeon General of the United States, reported at the 1990 AMA National Leadership Conference in reference to violence against women that ‘the medical community has yet to consistently identify the affected women as victims and extend treatment beyond the physical manifestation of an abusive relationship.’”

“Health care providers, not police nor the legal system, may be the only persons with whom the victim of violence will make contact and ask for help directly or indirectly.”

estimated that 21% of all women using emergency services were there for sequelae of domestic violence, and rather than stating abuse as the problem, abused women were more likely to present with depression, anxiety, family-marital-sexual problems and vague medical complaints. Health care providers, not police nor the legal system, may be the only persons with whom the victim of violence will make contact and ask for help directly or indirectly.

Pregnancy is a particularly high risk time for an abused woman. Advanced stages of pregnancy leave her vulnerable and unable to avoid trauma to herself as well as the unborn child. Physical violence during pregnancy has been linked to low birth weight. Because of the high incidence of women who are assaulted during pregnancy, those providing pre- and postnatal care have an excellent opportunity to identify this abuse and reduce potentially negative outcomes. This scenario does not stop here, however, for in fact studies also find that mothers who are the victims of frequent abuse are more likely to victimize their children than nonabused mothers.

The issue of elder abuse continues to gain more attention. Again, failure to recognize this in our patients allows it to become a repeatable event, when in fact with proper intervention by respite services

and other community based social agencies, much of this could hopefully be alleviated.

The role of substance abuse in the offending population (victimizer) is readily gaining identification. It is reported that in matters of family violence, one third of the victimizers are alcoholics and there is a higher correlation with other forms of substance abuse. An even more controversial issue linked to the subject of family violence has to do with the presence of the accessibility to firearms.

The elements related to family and interpersonal violence are numerous. The numbers of lives touched, lives lost, and the total impact on the health care system by

“Physicians much of the time are ill prepared to recognize, treat, and prevent this form of public health problem. The AMA has included this issue as one of its major agenda items for the future, and their efforts are to be applauded.”

violence of this nature makes this an urgent issue which we as Kentucky physicians must continue to address and give our increased efforts.

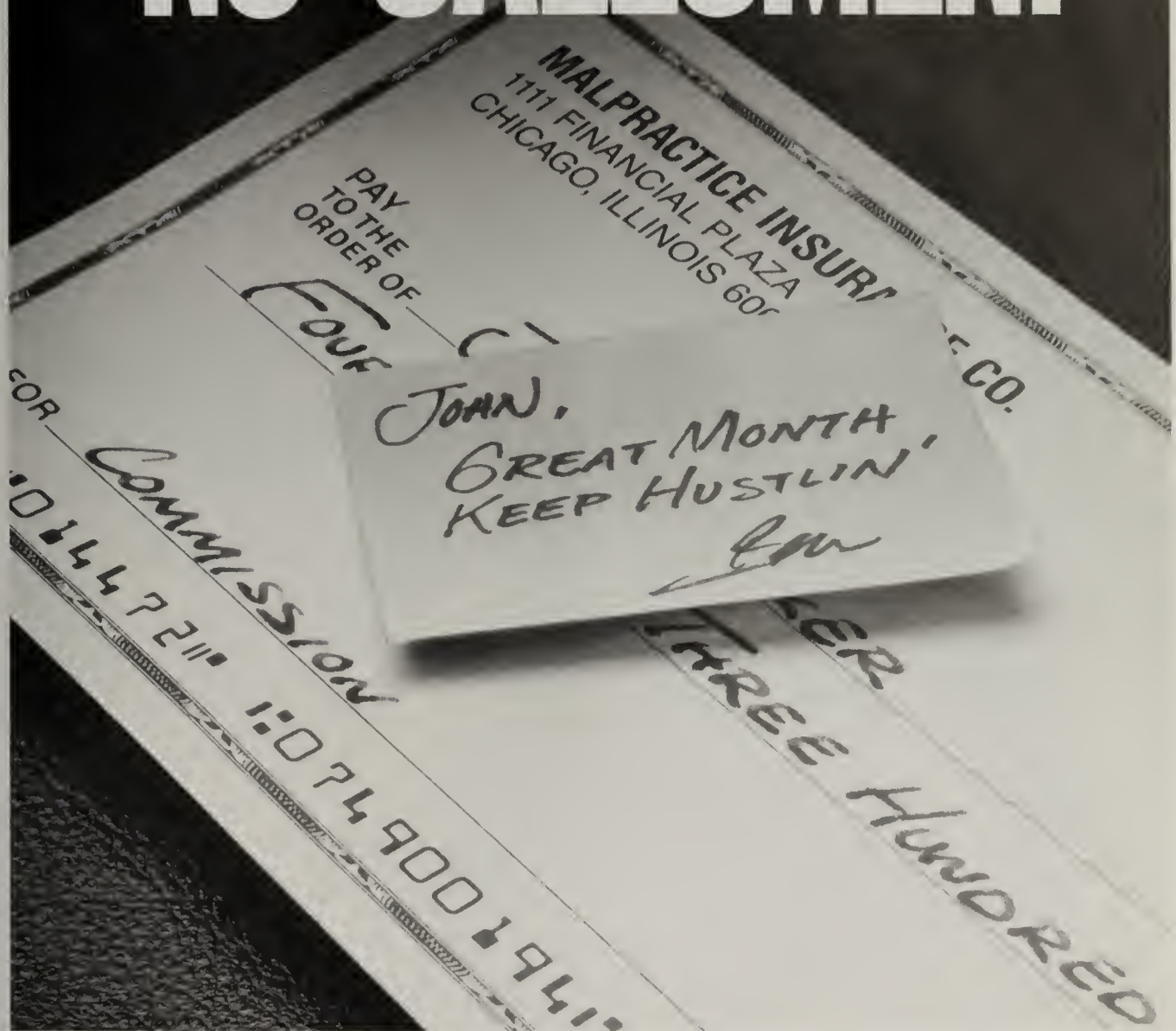
The following areas have been identified as areas where physicians may take a leading role against family violence and interpersonal abuse:

1. Physicians must become aware of and knowledgeable about the diagnosis and treatment of family and interpersonal violence.
2. All physicians must become familiar with abuse reporting laws and legal requirements as well as appropriate procedures for referring suspected cases of abuse.
3. Physicians can be helpful in educating other professional groups about the physical and mental health problems related to family violence.
4. Physicians should be involved in legislative efforts in areas of domestic violence and elder abuse.

We as physicians have the opportunity and the responsibility to deal with this public health problem. In the coming year information will be made available to us via the American Medical Association regarding this vital problem. I heartily urge all interested in this area to communicate their interest to the KMA and take an active role in their local community and in the Kentucky Medical Association.

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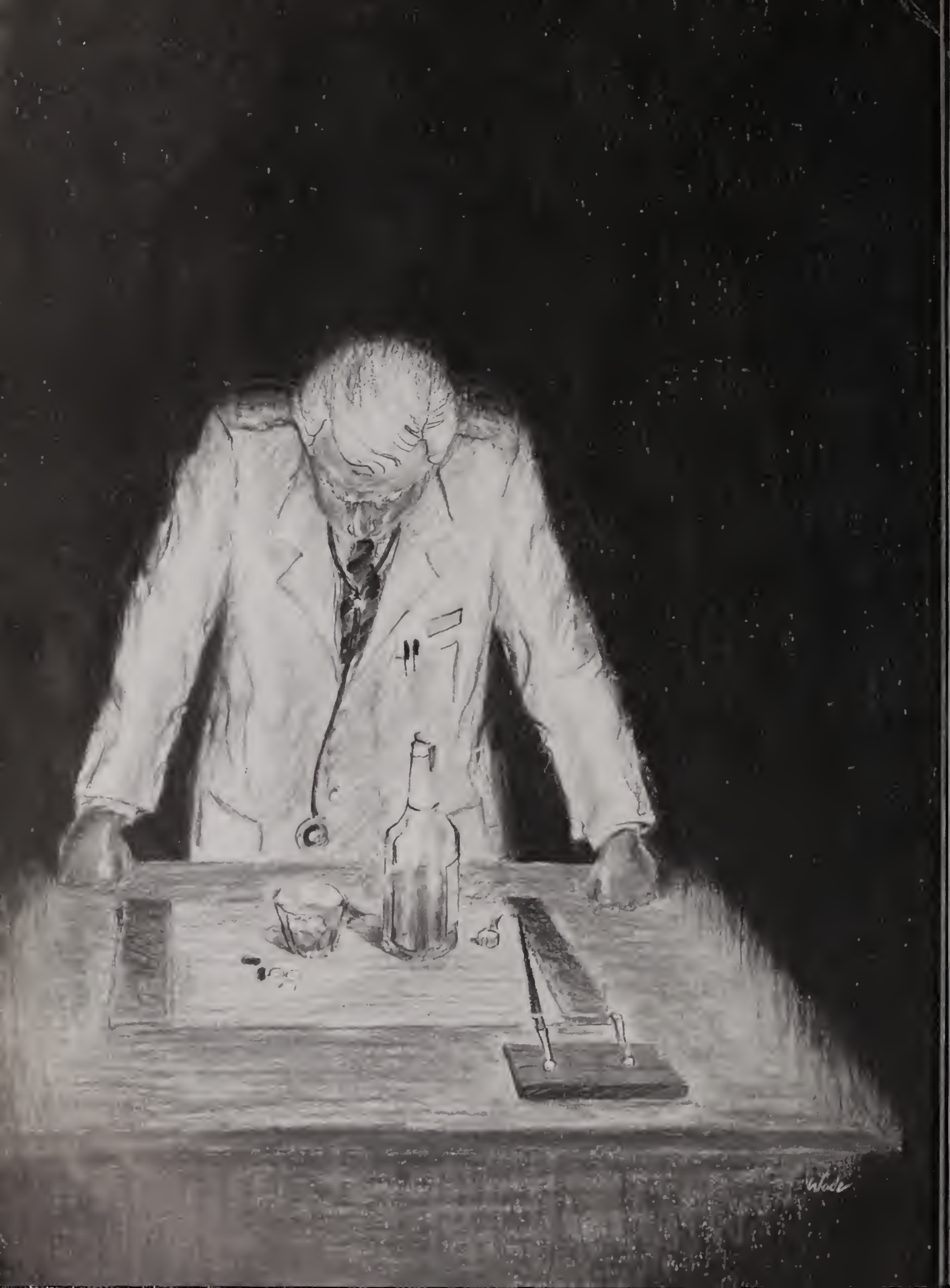
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Impaired Physicians: The Kentucky Experience

Richard D. Blondell, MD

Since 1976 the Committee on Impaired Physicians of the Kentucky Medical Association has become involved with 134 physicians. Most were referred because of possible substance abuse. These physicians represent a wide range of ages and specialties. The Committee typically follows approximately 35 physicians at any given time. Many recover from their problem and are able to return to practice. However, the Committee is aware of only a minority of the impaired physicians that might exist in Kentucky. To be more effective and to reach more impaired physicians, the Committee will need to expand its mission and obtain more resources.

A recently published prospective study of a group of medical students indicated that these students have identifiable precursors which predict alcohol abuse as physicians later in life.⁴ Yet the average chemically dependent physician does not usually enter treatment until the fifth decade of life, often when clinical skills are compromised.^{5,6} Thus, there appears to be a missed window of opportunity for chemically dependent physicians lasting about 20 years between medical school and professional impairment. An alliance of ignorance and denial often conspire to assure that chemically dependent physicians pass by opportunities to receive help.^{7,8,9} This is unfortunate because physicians are more likely to recover from chemical dependency than the general population.^{10,11,12} The fortunate impaired physician will enter treatment, recover and be a valuable member of the profession. Those less fortunate may experience premature death because of trauma (eg, motor vehicle accidents), suicide, or drug overdose. Medical societies across the country have organized efforts to avert these tragedies and help save physicians from the grip of chemical dependency. The Kentucky Medical Association (KMA) is one of those organizations.

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Introduction

Physicians who are cognitively impaired by organic disease, mental illness or substance abuse are a concern both to the profession and to the general public. Great controversy exists about how to deal with the most common impairment, substance abuse. The facts are often obscured by the shadow of opinion.

It is widely believed that physicians have higher rates of chemical dependency than the general population because of their stressful occupation and access to drugs. However, a recent review of the literature indicates that when alcohol and drugs are considered together, the prevalence of chemical dependency among physicians is probably the same as the general population, about 12%.¹ Thus, there may be up to 790 physicians who are or may become chemically dependent among the approximately 6600 licensed physicians who reside in Kentucky. Taking only a punitive approach to these chemically dependent physicians would have Kentucky waste a valuable health care resource.

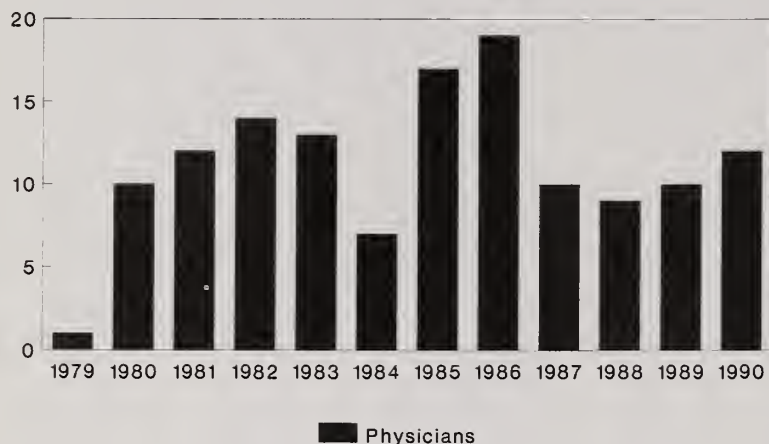
Chemical dependency is a clinically heterogeneous disorder. The etiology is poorly understood, but a component appears to be genetic.^{2,3}

The Committee on Impaired Physicians

The KMA established the "Committee on Physician's Health" in 1976 to assist impaired physicians. Under the leadership of the late Dr David Stewart, the committee spent its early years defining its mission and promoting its existence. By 1981 the committee was following the progress of 15 impaired physicians.¹³ The committee's name was changed that year to the "Committee on Impaired Physicians" to reflect a national trend. It is also commonly referred to as "the impaired physician's committee" or the "IPC." In the mid-1980s the KMA established the "Benevolent Fund" that could be used to assist physicians in

Impaired Physicians

Figure 1
Number of Physicians Referred to the IPC
per Year, N=134



need. This fund has been useful as a way to provide loans to physicians for substance abuse treatment.

The purpose of the IPC is to help the physician. The physician is given encouragement and guidance to continue recovery from chemical dependency. When appropriate, the IPC is the physician's advocate with the Kentucky Board of Medical Licensure (KBML), malpractice insurance carriers, or hospital credentialing committees.

Membership on the IPC is voluntary and includes representation from the KBML, the KMA Auxiliary, and medical student groups for a usual total of 12 members. These representatives reflect a variety of specialties and practice locations. Some members have had substance abuse problems in the past and bring to the committee important firsthand experience. The activities of the IPC are supported by the KMA staff.

Physicians suspected of impairment come to the attention of the IPC through a variety of sources. The response of the IPC will vary depending upon the circumstances of the referral. When the impairment is obvious the response is swift. Some physicians have been hospitalized for treatment the day the referral was made. At other times the IPC may take time to gather information before taking action. Sometimes no impairment is found and no action is taken.

At one point in the process, the physician in question is asked to appear before the committee at one of its bimonthly meetings. If the physician decides that the IPC can be of some help, then the IPC will offer the physician a "contract." This is considered to be a "moral document" and is not meant to be a legally binding agreement. Instead it outlines the relationship between the physician and the IPC and acts as a mutual commitment to the physician's continuing recovery. The physician's relationship with the IPC is voluntary, but cooperation is usually the rule.

In contrast to the IPC, the function of the KBML is to protect the public. Although the impaired physician's involvement with the KBML is mandatory, the KBML must follow the principles of due process. On the other hand, the IPC can act on hearsay. Because the goals and methods of the IPC and the KBML are complimentary, a good working relationship has developed between the two organizations for the benefit of the impaired physician and the general public. For example, that the impaired physician's license is often in jeopardy helps motivate that physician to cooperate with the IPC and maintain recovery.

The IPC may cease to follow the progress of a physician for any number of reasons and this is referred to as a "closed case." Such reasons include: no confirmation of impairment, several years of recovery, or retirement. The IPC may also cease to follow a physician if the physician declines the assistance of the IPC or if it is more appropriate for the KBML or the courts to handle the situation. If the physician moves to another state, the IPC will no longer follow the physician but will notify the appropriate organizations in the new state.

Methods

Since the IPC's relationship with impaired physicians has tended to be informal, only a limited set of records have been maintained. No standard data set has been compiled on every physician who has been referred to the IPC. Nevertheless, some documents do exist from which data could be extracted. These documents were reviewed by the KMA staff who work with the IPC. In this way, the following items were determined for each case that was referred to the IPC as of December 1990: (1) date of referral; (2) the source of the referral; (3) nature of the suspected impairment; (4) the specialty of the referred physician; (5) the

current status of the relationship that the physician has with the IPC; and (6) the date of the birth of the physician.

Results

Since 1979 when the committee began to function, 134 physicians have been referred to the IPC. Annual referrals peaked in the mid-1980s and have declined in recent years (Fig 1).

The date of birth was recorded for 106 of the 134 physicians referred to the IPC. The age distribution of these 106 physicians is shown in Fig 2. The average age of a physician at the time of referral to the IPC was 44 years.

The source of the referral was not recorded for 61 cases (45.5%), but the origin of the others were: 27 (20.1%) from the KBML; 13 (9.7%) from physician colleagues; 13 (9.7%) from an IPC member; 12 (9.0%) from hospitals or employers; and 8 (6.0%) from other sources.

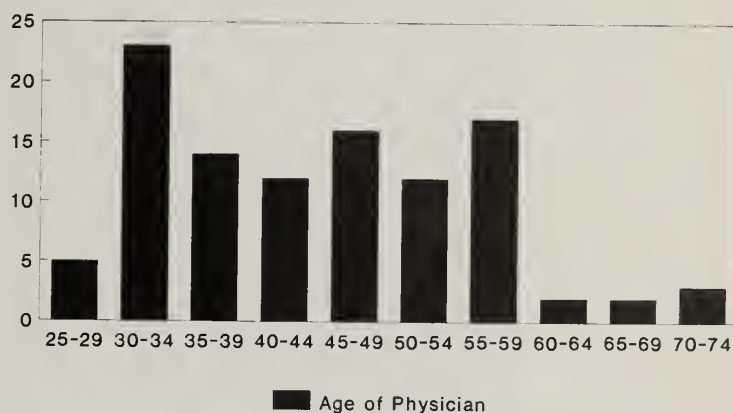
Suspected substance abuse accounts for the majority of referrals (109/134 or 81.3%). Specifically, 34 (25.3%) were reported to have problems with alcohol alone, 36 (26.9%) with other drugs, 15 (11.2%) with both alcohol and drugs, and 9 (6.7%) were reported to have substance abuse, not otherwise specified. In addition, 15 (11.2%) physicians were felt to have both a psychiatric and a substance abuse problem. Seven physicians (5.2%) were referred because of psychiatric problems alone (generally schizophrenia, paranoid depression, or manic-depressive disorders). Six physicians (4.5%) were referred because of possible organic impairment (eg, dementia). The nature of the problem was either not recorded or was not confirmed for the remaining 12 (9.0%) physicians.

The specialty distribution of the physicians referred to the IPC is shown in Table 1. Of the 134 physicians who have been referred to the IPC, 96 (71.6%) are not being actively followed and are considered "closed cases." As of December 1990 the IPC was following the activities of the remaining 38 physicians. Thirty-four of these 38 physicians were able to remain in active practice. Of the remaining four, two were working in medically related fields, one was still involved in treatment, and one was retired.

Discussion

The 134 physicians who have been referred to the IPC during the last 11 years represent only a

Figure 2
Age of Physician at the Time of Referral
to the IPC, N=106*



■ Age of Physician
Date of birth was not recorded for 28 individuals

fraction of the estimated 790 physicians in Kentucky who are or may become chemically impaired. Even if no new chemically impaired physicians begin practice in Kentucky, it will take the IPC decades to close this gap given the current rate of new referrals. Also of concern is the fact that the rate of new referrals to the IPC appear to be decreasing. It stood at about 18 physicians per year in the mid 1980s, but is only about 11 per year now. Few of these referrals come from physician colleagues or family members who are likely to be aware of a physician's impairment.

Table 1. Specialty Distribution of Physicians Referred to the IPC

Specialty	Number	Percent of Total
General Practice/Family Practice	35	26.1
Internal Medicine	7	5.2
Pediatrics	2	1.5
Surgery	11	8.2
Emergency Medicine	3	2.2
Anesthesiology	10	7.5
Psychiatry	8	6.0
OB/GYN	9	6.7
Students, Residents, Fellows	8	6.0
Other	21	15.7
Not Recorded	20	14.9

Impaired Physicians

In some ways the IPC is a victim of its own success. During its first few years the IPC followed few physicians and much of its efforts were directed at promoting its existence and reaching out to physicians in need. Referrals to the IPC increased rapidly at first. This required the IPC to redirect its attention to helping these physicians. Less time was directed at promotion, which eventually resulted in fewer referrals. Reliance on self-identification and selection has the inherent weakness that not all those physicians who need help will get help. Family members and colleagues of an impaired physician will also deny that any problem exists in attempt to protect the physician from social stigmatization or economic hardship. This would account for the fact that the average age of a referral to the IPC is 44 years. Yet many of these impaired physicians began to abuse alcohol or drugs while in college, medical school, or during residency. Nevertheless, even the physician who is referred to the committee after years of substance abuse is fortunate because recovery is still possible. Those family members or colleagues who "protect" the impaired physician from treatment may witness the impairment grow from a treatable condition to a terminal one.

Recommendations

Adopting more proactive strategies to improve the detection and treatment of chemically dependent physicians will serve to assure that impaired physicians get help early. These strategies might include outreach programs in hospitals or local medical societies. Educational programs directed at non-impaired physicians can give those physicians the skills that they need to be able to reach out and assist their impaired colleagues. Educational programs are especially important in medical schools and residency programs. Once the physician leaves the training environment it is more difficult to identify chemical dependency until there is obvious impairment. Local organizations such as hospitals and county medical societies could also become more active with this problem.

Information about physicians who have been referred to the IPC has not been collected in a systematic manner. Because of this it is not possible to interpret the distribution pattern of impaired physicians by specialty or geographic

location. Ideally, it would be useful to know if there are specialties which are "high risk" for physician impairment or if there are geographic areas in which impaired physicians are able to avoid detection. This information could be used to help plan outreach activities. The IPC is also unable to evaluate the outcomes of its efforts. It would be very useful to know which kind of treatment produces the highest rates of recovery among Kentucky physicians. Establishing a database is one way that these questions could be answered.

The IPC needs to plan for the future. A reasonable objective for the IPC would be to increase the referral rate to 20-30 new cases per year. Over the next 5 years this would generate 100-150 new referrals and would result in the IPC actively following about 100 physicians. Another reasonable objective would be to decrease the average age of those physicians referred to the IPC to less than 40 years. Finally, it would be useful to maintain a database that can be used to evaluate the progress that the IPC makes towards fulfillment of its objectives and the outcomes of its interventions. For example, it is reasonable to expect that 90% of physicians can recover from alcoholism or drug addictions. Because of incomplete data, it is not known if Kentucky physicians have this rate of recovery.

In 1985, it was noted that the IPC's voluntary structure might not be able to meet the needs of the physician community in the future.¹⁴ The goals and objectives outlined above would undoubtedly be beyond the means of the volunteers who serve on the IPC. Ultimately, full-time individuals will be needed to supplement the efforts of the volunteers.

Funding these programs is never easy. In Kentucky, the financial support for the IPC is from the KMA membership. Yet other physicians, hospitals, and others also benefit from the activities of the IPC. In other states which have more extensive programs than Kentucky's, a variety of funding sources have been used. In this way funds are provided by those who benefit. These funding sources have included: surcharges on licensure fees, malpractice insurance carriers, hospitals, and hospital staff organizations, in addition to the traditional funding sources of state, county, and specialty medical societies. Increasingly, the individual physician who directly benefits from the program, the recovering physician, has also been used to provide financial support.

Conclusion

Expanding the activities of the IPC will serve to help more Kentucky impaired physicians. Nationally, many groups that assist impaired physicians have evolved over time. Most began as small, discreet groups that supported physicians in the recovery process. Then these groups began to reach out in order to identify more physicians who needed to be encouraged to get help. Recently, groups have adopted proactive strategies and have become more coercive in order to help more physicians into recovery earlier in the course of their illness. Some programs have begun to conduct outcome oriented research to find ways to be more effective.

Although the IPC has made significant progress in assisting chemically dependent physicians during the last 11 years, there are many more physicians who need help. Kentucky cannot afford to lose 10% of its physicians to become the slaves of alcohol and other drugs. Many recovering physicians provide excellent patient care and are often especially skilled at caring for chemically dependent patients. Recovering physicians can also be extremely effective in educating medical students, residents, and the general public about substance abuse. Helping impaired physicians is an investment in the health care provider resources of our state.

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Help for Impaired Physicians

Through its Committee on Impaired Physicians, KMA helps doctors who are suffering from alcoholism and drug addiction. The thrust of the program is rehabilitative, not punitive. The Committee is composed of physicians who have special expertise in these areas, some from personal experience. Effective treatment for these illnesses is achieved most easily when the disease is detected early; family, friends, and associates are urged to avoid misguided sympathy which enables the condition to deteriorate.

HELP US TO HELP

Call the KMA Impaired Physicians Program
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Amyloidosis: Current Approaches for Diagnosis and Treatment

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Amyloidosis is a disease that results from the extracellular deposition of fibrous proteins in many tissues.¹ Its diagnosis is a difficult and challenging one, requiring first and foremost a high index of suspicion. The diagnosis is made by demonstrating amyloid in an appropriate tissue sample and by using special techniques to identify the nature of the amyloid. After the diagnosis of amyloidosis has been established, it is necessary to assess the organ dysfunction for optimal patient care. In this paper, we report two patients with amyloidosis of the AL type and discuss the methods that are currently used for the diagnosis and treatment of amyloidosis.

Case Summaries

Case 1 — The patient is a 54-year-old white male who presented to the emergency room after he awoke from sleep with a blackened right eye (Fig 1). He was known to have multiple myeloma (IgG k type) for 3 years and had received 18 courses of melphalan and prednisone. Not long after the diagnosis was made he began experiencing an unpleasant burning sensation, first in his legs, and then over his entire body. One year later he developed symptoms of weight loss, fatigue, and anorexia. Chemotherapy consisting of vincristine, adriamycin, and dexamethazone was started at that time but was followed by an episode of congestive heart failure. A few months later he developed intractable diarrhea, hepatomegaly, and ascites.

Physical examination on presentation to the hospital was significant for jugular venous distention to the angle of the jaw, a laterally displaced PMI, and rales in both lung bases. His liver was enlarged to 14 centimeters and was firm. Shifting dullness and a fluid wave were also present.

Significant laboratory data included a hemoglobin of 11.3 gm/dl, a total protein of 8.5 gm/dl, an albumin of 3.5 gm/dl, a blood urea nitrogen of 25 mg/dl, a creatinine of 1.0 mg/dl, a serum calcium of 9.0 mg/dl, and an alkaline phosphatase of 150 U/dl. Bone survey revealed extensive lytic lesions.

A 2-dimensional echocardiography (2-D echo) done during his first episode of congestive heart failure revealed left ventricular hypertrophy,



Fig 1 — Pinch Purpura representing spontaneous hemorrhage into the soft tissues surrounding the eye.

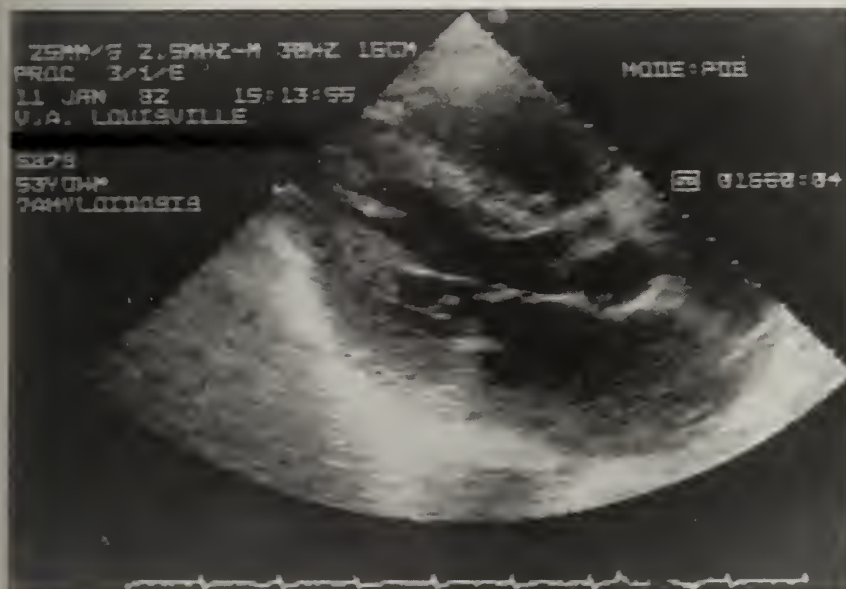


Fig 2 — 2-D echo demonstrating the classic hyperrefractile, granular, sparkling appearance of the myocardium as seen in cardiac amyloidosis.

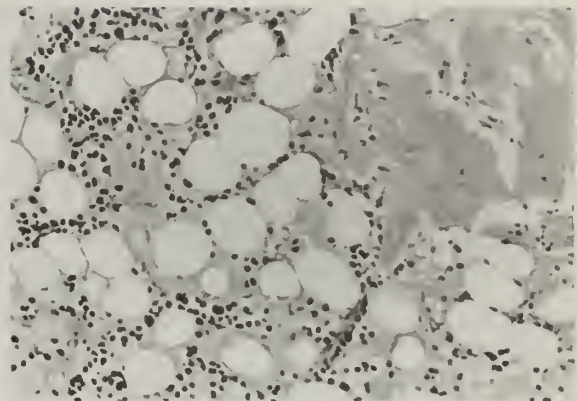


Fig 3 — H-E stain of the bone marrow biopsy showing numerous plasma cells and large amounts of an amorphous material representing amyloid (magnification x 150).

biatrial enlargement, global hypokinesis, and an abnormal E/A ratio consistent with diastolic dysfunction. The findings on the echo were suspicious for amyloid but were not diagnostic. A second 2-D echo done a few months later showed a worsening of the above signs and a third done on the present admission showed findings that were classic for cardiac amyloidosis (Fig 2).² Rectal and fat pad biopsies did not reveal evidence of amyloidosis; however, a bone marrow biopsy showed many plasma cells and large amounts of an amorphous eosinophilic material (Fig 3). This material, when stained with congo red and examined under a polarizing microscope, demonstrated green birefringence (Fig 4). Immunohistochemical studies done on the bone marrow specimen showed that the amyloid was a kappa chain immunoglobulin. The patient is currently being treated with melphalan and prednisone with little change in his symptoms.

Case 2 — The patient is a 57-year-old black female who presented for evaluation of a benign lipoma on her leg. She was relatively asymptomatic at the time but was noted to have hepatosplenomegaly and a platelet count of 800,000. All laboratory studies, including liver function tests, were normal. A bone marrow examination revealed many



Fig 4 — Congo red stain demonstrating the green birefringence of amyloid (arrow) when examined under a polarizing microscope (magnification x 150).

abnormal plasma cells (20 to 30%) secreting lambda light chains and IgA immunoglobulin. A diagnosis of plasma cell dyscrasia, most probably multiple myeloma, was made. A skeletal survey, however, failed to reveal any evidence of lytic lesions. A rectal biopsy was done which revealed the diagnosis of amyloidosis of the AL type. She

Amyloidosis

Table 1. Classification of Amyloidosis¹

Type	Clinical Form	Fibril Homologies
AL	1. Primary amyloidosis 2. Multiple Myeloma associated amyloidosis	N-terminal portion of light chains
AA	1. Secondary amyloidosis 2. Amyloidosis associated with Familial Mediterranean fever	N-terminal portion of SAA
AF	1. Familial amyloidosis	Prealbumin
AE	1. Amyloidosis associated with medullary carcinoma of the thyroid	Calcitonin
AS	1. Senile amyloidosis	Prealbumin
AB-2M	1. Dialysis associated amyloidosis	B-2 microglobulin
CAA	1. Cerebral amyloidosis	A-4 or B
IAA	1. Atrial amyloidosis	Atrial natriuretic factor
IAPP	1. Amyloidosis of type II diabetes	Insulin polypeptide

is currently being treated with melphalan and prednisone with little improvement.

Discussion

Amyloidosis results from the degradation of circulating proteins and the deposition of the degradation products in the body tissues. The disease can be classified according to the type of protein involved (Table 1). In primary amyloidosis and amyloidosis associated with multiple myeloma, the amino terminal portion of light chains is deposited. In chronic inflammatory states such as tuberculosis, chronic osteomyelitis, and rheumatoid arthritis, macrophages are stimulated to produce Interleukin-1. Interleukin-1 stimulates the liver to produce a protein designated as SAA. The amino terminal fragment of SAA is deposited throughout the body in AA amyloidosis. Familial and senile forms of amyloidosis result from the deposition of an altered form of prealbumin.³ Other even rarer forms of amyloidosis have been noted. Isolated atrial amyloidosis develops from a product of atrial natriuretic polypeptide. Amyloidosis surrounding cerebral vessels (cerebral amyloid angiopathy) seen in patients with senile dementia results from the deposition of a protein designated as A4 or B, and amyloidosis found in

chronic hemodialysis patients is composed of a protein similar to B-2 microglobulin. Amyloidosis of the pancreas in some Type-II diabetics and of the thyroid in patients with medullary carcinoma is secondary to deposition of an islet polypeptide and a calcitonin subunit respectively.¹

The clinical manifestations of amyloidosis are varied according to the organs involved. Spontaneous hemorrhage into the soft tissues of the periorbital area (pinch purpura) as seen in patient number one is a classic sign for amyloidosis and is thought to be secondary to the increased friability of the blood vessels surrounded by amyloid. Involvement of the liver and kidney results in enlargement of these organs. Liver function tests are usually unremarkable with the exception of an elevated alkaline phosphatase. Neurological manifestations include a dysesthetic peripheral neuropathy, autonomic neuropathy, and carpal tunnel syndrome. Renal involvement results in proteinuria and, eventually, azotemia. Gastrointestinal involvement may include direct infiltration of the bowel wall resulting in malabsorption, obstruction, and ulceration or autonomic neuropathy resulting in diarrhea and incontinence. Macroglossia secondary to infiltration of the tongue is classic in AL type amyloidosis; however, it was not present in patient number one. Amyloid also infiltrates articular structures resulting in arthropathies.¹ The cardiac manifestations of amyloidosis include diffuse infiltration of the myocardial tissues and a restrictive cardiomyopathy. Early findings include a thickened ventricular free wall, small ventricular chambers, and dilated atria. Findings in advanced disease include systolic dysfunction and a granular, sparkling appearance on 2-D echo. 2-D echo is thought to be very sensitive in detecting cardiac amyloidosis and may be helpful in following the progression of the disease.²

Amyloidosis should be suspected in any patient with a predisposing condition such as multiple myeloma or a chronic inflammatory disease who presents with multi-organ system dysfunction. Patient number one was known to have multiple myeloma and multi-organ system dysfunction including a peripheral neuropathy, cardiomyopathy, chronic diarrhea, hepatomegaly, and spontaneous hemorrhage. The diagnosis of amyloidosis was strongly suspected for many months, but had remained elusive despite the initial attempts of rectal and fat pad biopsy. Bone marrow biopsy, which is typically a low-yield procedure, finally allowed the diagnosis to be made.

The diagnosis was much simpler in patient number two with the plasma cell dyscrasia and hepatosplenomegaly.

The diagnosis of amyloidosis requires the demonstration of amyloid either with the congo red stain or by electron microscopy. Biopsy of clinically suspected organs, such as an endomyocardial, kidney, or liver biopsy, results in the greatest yield (>90%).⁴ However, it also has the greatest potential for causing morbidity. For this reason, other less invasive and safer methods have been investigated. Rectal, subcutaneous fat pad, gingival, skin, and bone marrow biopsies are often done in order to obtain a diagnosis. Sensitivities for each of these tests are shown in Table 2. The rectal biopsy appears to yield the best and most consistent results and is usually the initial procedure of choice. Gertz et al⁴ in a study of 31 patients with known amyloidosis other than those with carpal tunnel syndrome alone, showed that none of the patients had negative rectal, fat pad, and bone marrow biopsies. In other words, each patient had a diagnostic biopsy in at least one of the 3 biopsy areas. This shows that the 3 procedures can be used in a complimentary fashion. If the above procedures fail to yield a diagnosis, and the clinician is still suspicious, biopsy of a known affected organ is the best test.⁵ It should be remembered, however, that organs infiltrated with amyloid, such as the liver, are much more prone to bleeding for the same reasons they tend toward spontaneous hemorrhage, as discussed previously.⁵

Identification of the specific type of amyloidosis is important because the treatment of each type varies. Immunohistochemistry using specific antibodies to immunoglobulin light chains, the AA protein, and prealbumin have been used successfully to determine the specific type of amyloid present.¹⁷ It is crucial that the clinician be aware of this so that he can alert the pathologist to the importance of performing these studies.

Treatment of amyloidosis has generally been unsuccessful. Alkylating agents such as melphalan have been used for AL types of amyloidosis with a response rate of 18%.¹⁸ Colchicine has been used in amyloid associated with familial Mediterranean fever with some benefit.¹⁹ Treatment of the underlying inflammatory disease may improve symptoms in some patients with secondary amyloidosis, however the addition of D-penicillamine, chlorambucil, and dimethylsulphoxide have generally not been helpful.¹⁹

Table 2. Diagnostic Sensitivities of Tissue Biopsies

Tissue	Sensitivity	Reference
1. Kidney and Liver	> 90%	4
2. Rectal biopsy	70-85%	4, 6, 7, 8, 20
3. Fat pad	54-70%	4, 6
4. Bone marrow	10-89%	9, 10, 11, 20
5. Gingiva	20-77%	6, 12, 13, 14
6. Skin	41-80%	15, 16, 17

The prognosis for patients with systemic amyloidosis is poor with most dying of end-stage renal and cardiac failure. The median survival of patients with congestive heart failure is about 7 months and with renal failure about 17 months.¹ Their course can be followed by reassessing immunoglobulin levels, liver and spleen size, and other parameters of organ dysfunction such as 2-D echo and level of proteinuria.

Summary

Amyloidosis is a complex disease resulting from the extracellular deposition of fibrous degradation proteins in body tissues. The type of protein deposited determines the class of amyloidosis present. Morphological, cytochemical, and immunohistochemical studies allow one to precisely identify the class of amyloid present and, therefore, more appropriately select a therapy. Rectal biopsy is the preferred initial procedure for obtaining tissue for study; however, subcutaneous fat pad, gingival, skin, and bone marrow biopsies are alternative noninvasive biopsy sites. We have presented two patients with multiple myeloma and amyloidosis of the AL type. One patient presented with multi-organ failure of undetermined etiology and the other with asymptomatic hepatosplenomegaly. The diagnosis of amyloidosis was made by bone marrow biopsy in the first patient and rectal biopsy in the second patient using morphological studies and confirmed cytochemically with the congo red stain. The type of amyloidosis was determined with immunohistochemical studies. Their clinical course and response to therapy will be assessed by repeated immunoglobulin studies, liver and spleen size, and studies for organ dysfunction such as 2-D echo and level of proteinuria.

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The Ilizarov Method (Callus Distraction) in the Treatment of Open Fractures of the Tibia

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The treatment of bone defects, in particular open fractures of the tibia, represents a significant health care concern for physicians and surgeons in the Commonwealth. Traditional methods of treatment, including those that utilize internal and/or external fixation devices, often have drawbacks. The Ilizarov method (callus distraction), which combines acute shortening with subsequent lengthening using an external ring fixator, offers a new approach to treating bone defects. The authors describe the Ilizarov method, discuss Ilizarov's research and his development of the callus distraction technique, and review the growing body of English-language literature assessing the use of the Ilizarov method.

Open fractures of the tibia are a major source of disability to citizens of the Commonwealth. These injuries result in lengthy absence from employment; in many instances, they require amputation of the extremity. Approximately 20 such injuries are seen at the Chandler Medical Center annually, and many more are seen across Kentucky.

Bone defects are classified by type and subtype depending on the cause of the defect, with choice of treatment based on the type of bone involved, the severity of damage to surrounding tissues, and the amount of skin and tissue loss.¹ While simple bone fractures can be treated with casting, more severe types, such as comminuted or segmental fractures and those accompanied by bone loss and soft tissue damage, require more complicated procedures. For these injuries, treatment often includes the use of internal and/or external fixation devices, together with plates and

screws, to stabilize the bone. These techniques have been employed for years in the treatment of bone defects. However, their use has limitations. The care of open fractures requires access to the wound. Such repeated exposure may cause additional damage through desiccation and secondary infection to bone, vascular structures, and musculotendinous units. Even following wound healing, prolonged immobilization may be necessary to permit bone healing. In many cases the procedures fail due to infection, malunion, or nonunion.^{2,3}

In the 1950s the Russian orthopaedist Gavriil A. Ilizarov began research which culminated in the development of a method of external fixation treatment for bone defects. In the 1980s, as a result of the collapse of the Iron Curtain and the openness brought about by the Soviet policy of *glasnost*, Ilizarov's work and his alternative approach to treating bone defects were introduced first in Western Europe (Italy) and later in the United States. Ilizarov's callus distraction principle and his ring fixator offer exciting possibilities for the challenging treatment problem represented by the open fracture of the tibia.^{2,4}

The Ilizarov method consists of passing numerous perpendicular wires through the bone at regular intervals and attaching them to external rings and bars to stabilize the bone segment (see Fig 1). This configuration makes it possible to move bone at a specific rate and frequency, while simultaneously providing rigid fixation of the adjacent bone for ambulation.^{5,6,7,8}

Ilizarov's technique is called the callus distraction method. While rigid stabilization of two ends of a bone is provided, the bone itself may be lengthened to correct a short extremity. Rapid healing takes place in the site from which the

bone was stretched. This technique requires only a few small holes in the skin large enough for the passage of a small osteotome. This narrow, chisel-like tool is used with a mallet to cut circumferentially the cortex of the bone. Such a corticotomy leaves the marrow space intact. The low tensile strength of this portion of bone allows it to be easily stretched. The blood supply to the segment that is moved remains intact. This segment is "transported" 1mm/day as the patient turns the screw on the device. As the cortex moves apart, rapid cortical healing takes place. This results eventually in new bone formation in the donor site and in a longer extremity. The 1mm/day transport rate is based on Ilizarov's research, which indicated that a slower rate of distraction allows bony healing of the corticotomy site, thereby preventing distraction. Too rapid a transport rate causes pain and leads to fibrous union. In addition, blood vessel and nerve regeneration cannot keep pace with the more rapid rate of stretch.

The Ilizarov method is based on the results of over 30 years of orthopaedic, traumatological, and limb-lengthening research on animal and human subjects. In an early study of bone lengthening in patients with dwarfism, Ilizarov utilized histological analysis to develop measures of determining the rate of new bone growth, the rate of distraction, the formation of new vessels, and the lengthening of peripheral nerves innervating structures distal to the site of bone stretch.

During these early studies Ilizarov also established the conditions influencing the success of his method. The ideal situation is characterized by the absence of damage to (1) the bone marrow, (2) the blood vessels nourishing distal structures, (3) the periosteum, and (4) the surrounding soft tissue such as muscles, nerves, and fascia.⁶

For years, the Ilizarov method has been utilized by Soviet physicians. Paley⁹ reports on the success which the Russian physician Kuftiriyev has had using the Ilizarov method. According to Paley, Kuftiriyev has used Ilizarov's external fixator to treat 154 patients with femoral defects, 45 of whom also suffered osteomyelitis. Kuftiriyev reports having achieved bone union in all 154 patients with femoral defects and claims to have corrected limb-length discrepancy in 147 of the 154.

In the last 5 years, reports in English have begun to appear describing the use of the Ilizarov method to treat various types of bone defects. In a study of 25 patients, Hoffmann, et al.,² reported a high success rate using the Ilizarov device for

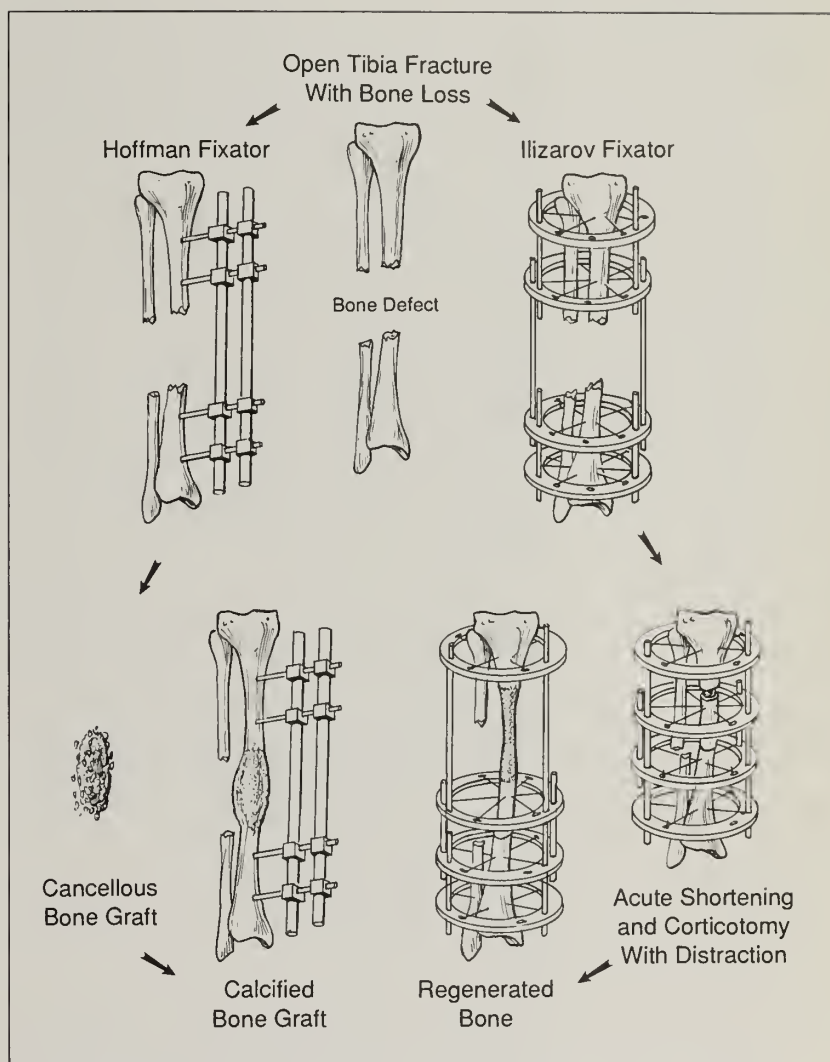


Fig 1

treating bone defects involving infection, non-union, malunion, mal-nonunion, and bone loss without bone grafting. Hoffmann and his colleagues achieved complete success with manageable complications in 15 of 25 cases. The remaining cases are still in treatment.

Utilizing a modified Ilizarov ring fixator, Alonso and Regazzoni¹⁰ successfully applied Ilizarov's distraction principle in the treatment of tubular bone defects. With their simpler, less time-consuming device they achieved positive results in bone healing and lengthening in a three-phase treatment regimen. Phase one, transportation, begins with a latency period of 5 to 7 days, after which distraction at the rate of 1mm per day is

Ilizarov Treatment Method

carried out in four steps. The transportation phase lasts from the initial formation of intramembranous ossification of the regenerated bone until the two ends of the defect advance and make contact. Phase two, maturation, extends to the point at which increased mineral content of the regenerated bone is observed. The third phase, consolidation, encompasses the period of increasing bone content and extends until the bone has healed. Based on their experience, Alonso and Regazzoni concluded that the Ilizarov distraction technique is ideal for segmental defects ≥ 4 cm. For smaller defects they recommend cancellous autografting or the Papineau technique. The authors also conclude that improved treatment outcomes could likely be achieved with further modification of the AO/ASIF tubular fixator, such as the addition of a motorized transport system.

The Ilizarov method has also been applied to severe chronic open fractures complicated by massive soft-tissue damage, chronic nonunion, and osteomyelitis. After his success in a series of experiments on dogs with induced comminuted fractures and bacterial contamination, Ilizarov⁵ conducted a study of 46 patients with similar open defects. Ilizarov employed a procedure which combined local compression with distraction of proximal and distal bone segments to accomplish bone lengthening and bone union simultaneously. Bone union and lengthening to normal bone length were achieved in 42 of 46 patients.

The Ilizarov method has been applied successfully in the treatment of tibial defects in particular. Paley⁹ reported excellent results in 68.9%, fair results in 28.7%, and poor results in only 2.4% of the 170 patients he treated for nonunion of tibial defects.

Schwartzman¹¹ has also reported a high preliminary success rate using the Ilizarov method in patients with tibial nonunion. These patients had undergone multiple procedures, including bone grafting, fibular osteotomy, electrical stimulation, compression plating, intramedullary rodding, compression screws, external fixation, and free muscle flaps. Many of them had also experienced infection and angular or rotational deformity. Of 25 tibial nonunion cases he has treated with the Ilizarov method, Schwartzman has achieved union in 13. There has been one failure to date, with the remaining 11 cases still in treatment.

In 1990, Milicevic¹² published a case report of a patient who had suffered a severe lower leg

injury during an automobile accident. The injury resulted in bone, muscle, and skin loss. Using a modified Ilizarov apparatus, Milicevic succeeded in restoring function to the limb without the necessity of skin and bone transplantation. The bone deficit was corrected by "transportation" or sliding of a segment of bone.

Tucker, et al.,⁴ used the Ilizarov method in treating nine patients with nonunions and bone defects. These authors concluded that this method offers a reliable technique for treating chronic bone defects despite the time-consuming fixator adjustment and the high degree of patient compliance necessary for success. Importantly, Tucker and his colleagues suggest that the Ilizarov technique may also be suitable for the management of acute bone loss.

Despite questions about the function of nerves supplying the extremity¹³ and concern about the high level of surgical skill required for correct implementation,^{3,14} the Ilizarov procedure resolves a number of problems left unsolved by other methods. The Ilizarov method can be used to correct a wide variety of bone defects; it enables improved blood flow to the injured area; it insures the stability of the fixation; it permits early movement of adjacent joints; and it allows weight bearing.³

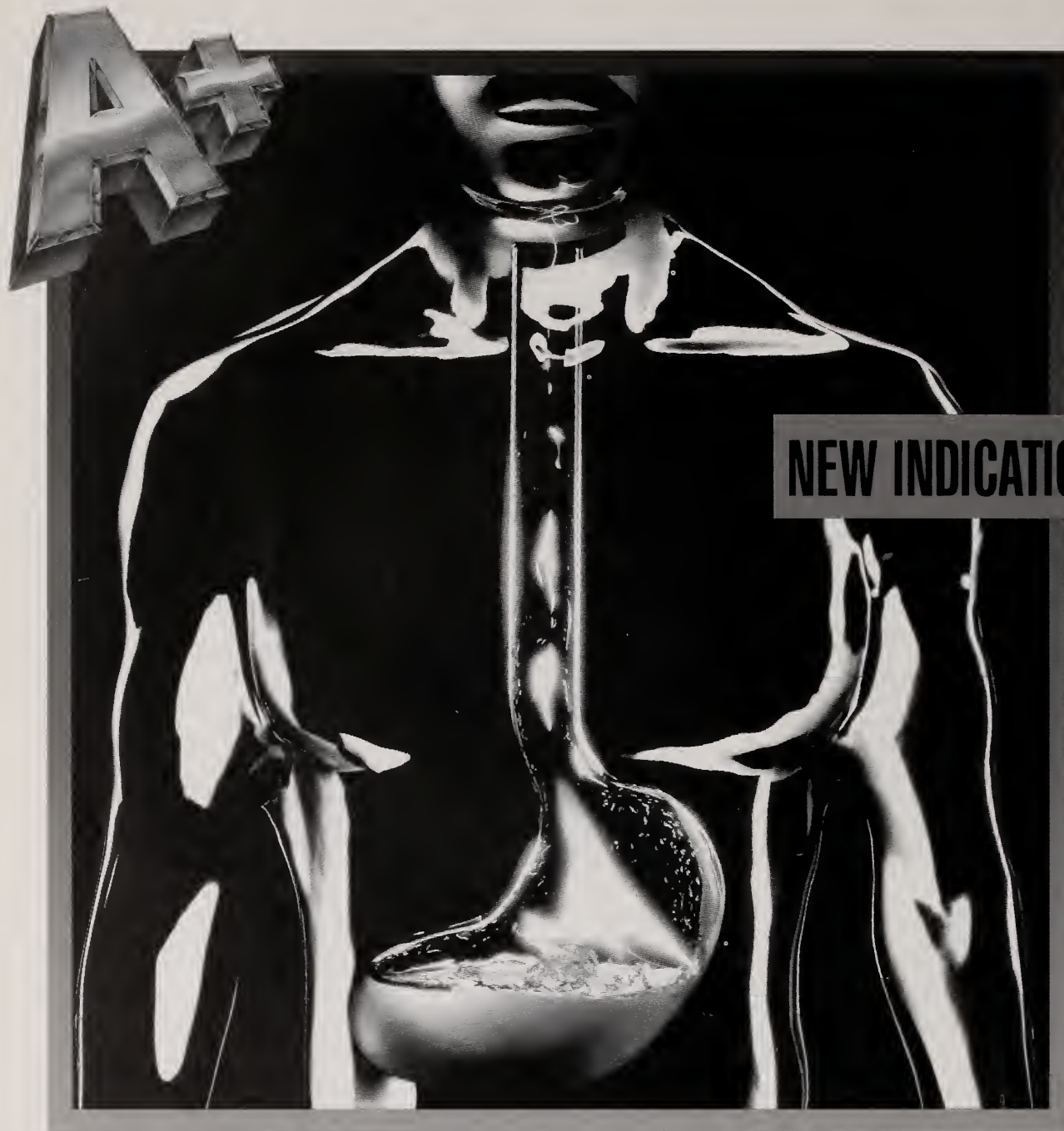
The majority of experience with the Ilizarov method relates to the treatment of bone abnormalities in the non-acute trauma setting. As the research cited above suggests, the principles of the Ilizarov method hold out exciting promise for the treatment of acute open fractures of the extremities. The University of Kentucky Chandler Medical Center is a Level-One Trauma Center where a large number of such injuries are seen each year. We are currently intrigued by the possibility of applying the principles elaborated by Ilizarov to treat patients at the University of Kentucky Chandler Medical Center. With the knowledge that the Ilizarov method makes it possible to return a shortened extremity to its original length, we can utilize acute extremity shortening to treat acute injury with greater confidence of a successful outcome. Acute shortening of the extremity holds many advantages. Nerves can be repaired without the need for intervening nerve grafts; blood vessels can be repaired with healthy ends without the need for intervening bypass grafts; healthy bone can be opposed to healthy bone to facilitate primary bone healing; and soft tissues can be approximated and in many instances closed with local tissues, thereby elimi-

nating the need for free tissue transfers. We are currently involved in a prospective randomized study comparing two methods of treatment of open tibia fractures: the traditional method, which consists of holding the extremity out to length and reconstructing the intervening damaged and/or missing parts; and a newer method, which combines acute extremity shortening with later lengthening.

We still have much to learn regarding the performance of the Ilizarov method in this context. We hope to report our findings to our associates in the Commonwealth in the near future.

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Brief Summary. Consult the package insert for complete prescribing information.

Indications and Usage: 1. *Active duodenal ulcer*—for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H₂-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H₂-receptor antagonists.

Precautions: General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix[®] may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

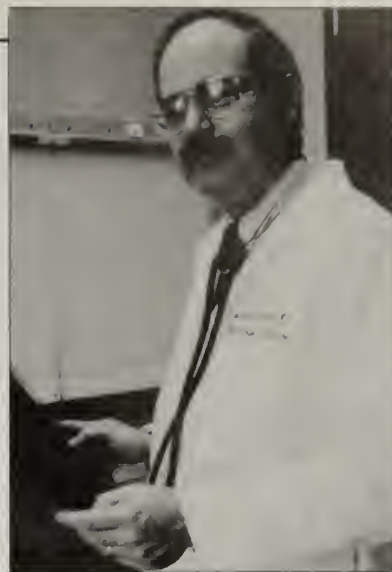
Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method. PV 2093 AMP [101591]

Additional information available to the profession on request.

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An Historical Perspective of the Mental Illness of Vincent Van Gogh

Michelle Macht, MS IV

The artist, Vincent Van Gogh, became one of the most highly valued of modern artists with the sale of *Irises* for \$53,900,000 on November 11, 1987. Long before this time, physicians, as well as others, had been intrigued by the works of this master. In fact, in 1942, A. J. Westerman Holstijn, MD, published the first article about the psychological development of Van Gogh. This paper has served as the nidus for over 100 other authors to analyze the life and artwork of Van Gogh.

In general, most of the authors have tended to make a retrospective diagnosis of his mental illness; and these have varied and included epilepsy, psychogenic neurosis, schizophrenia, schizoid psychopathic disorder, character disorders, bipolar affective/manic-depressive disorder (with and without psychosis), Meniere's disease, alcoholism, and addiction to absinthe, in addition to many physical ailments.

I tend to agree with Holstijn and Rahe, who have both stated that the matter of labelling the artist's mental illness is not as essential as is understanding his psychological development. There are profound parallels between Van Gogh's artistic evolution and his psychological growth, and it is this development that will be the focus of this article.

In 1852, exactly 1 year prior to the birth of her eldest son, a stillborn boy was born to Van Gogh's mother; but, most importantly, this infant was named Vincent. From the start of his lifetime, the second Vincent was troubled by seeing the headstone bearing the inscription of his own name every time he walked through the churchyard of the church where his father was pastor.

Many authors have described Van Gogh's childhood as being free from stressors, but it should be noted that he was the eldest of five children; and he was closest with his brother, Theo, who was born when Vincent was 4. In addition, at age 8, he was estranged from the family for doing

poorly in school; and 3 years later, he was sent away to a boarding academy. His academic performance never improved, even after changing schools.

In 1869, Van Gogh left school at age 16 to begin work as an art dealer's apprentice. He was a productive, valued employee until sometime after 1875 when the company fired him due to his odd behavior with customers and his religious preoccupation, which was interfering with his work.

During this period, at age 21, Van Gogh experienced the first of several disillusionments with love. He had fallen in love with a young girl and was rejected by her because she was already engaged. This disillusion recurred twice more in his life — once with a cousin whom his family refused to allow Van Gogh to court and the second time with a young woman who refused to see him again because he was "peculiar." These rejections led to depression that became obvious in the letters which Vincent began to write more frequently to his younger brother, Theo.

Following his dismissal from the art firm, Vincent's religious fanaticism grew. He attempted to pass the entrance exams in theology but failed; so, instead, he sought a career as an evangelist. Against the wishes of his superiors, he began evangelistic work in a mining town but was eventually fired from his work. This time he was rejected because of his self-abusive behaviors and poor hygiene. In turn, Van Gogh rejected religion; and, in his 27th year, he devoted himself to painting.

It was at this time that Theo began paying all of his elder brother's expenses as a painter; and, thereafter, Theo assumed the supportive father role in Vincent's life.

As a painter, Vincent traveled a great deal, learning from several artists in The Hague, Paris, Brussels, and the Antwerp Art Academy. For long

Mental Illness of Vincent Van Gogh

periods, he would live with his parents. He started and maintained a relationship with a prostitute, Sien, and her children for a while.

Both his family and friends began to notice his eccentric behavior. At times he would sit in a corner and speak to no one. He was considered a lunatic.

In 1885, when Van Gogh was 32, his father died. Although there was much that he and his father disagreed about, Van Gogh experienced a very deep sorrow.

Physical problems also plagued Van Gogh at this age. He had contracted venereal disease from Sien and had both dental problems and stomach problems, the latter assumed to be ulcers. He continued to smoke his pipe heavily and began to consume large amounts of alcohol and absinthe. Both his physical and mental health were deteriorating, and many individuals have noted the correlation with the dark colors of his artwork at this time.

In Paris, approximately 2 years later, Vincent lived with Theo; and his paintings displayed a different mood. Bright colors and yellows began to dominate his canvasses. Many critics, including Bonafonx, believed that Van Gogh's use of yellow in his paintings represented the sun which was a symbol of love for God and his father, which was then focused on Theo. His short time in Paris with Theo seemed to bring temporary recovery from the evitable mental illness which unfortunately led to his death.

Many physicians have attributed the rapid decline of Vincent Van Gogh's health to heavy smoking, overworking, sun exposure, alcoholism, and undernourishment; but two important events happened in 1888 that could have triggered Van Gogh's crisis. First of all, Theo became engaged to be married. Afterwards, Vincent must have felt abandoned and rejected once more; so he focused all of his energies on building a friendship with another artist, Paul Gauguin. As fate would have it, Gauguin thought Van Gogh's idea to develop a society of painters was bad and, thus, ruined Van Gogh's last chance at stability.

Lutsin has concluded that, as a result of this rejection, hostility grew towards Gauguin and mounted into a confrontation. Van Gogh followed Gauguin into the street with a razor blade in his hand, only to be turned away by Gauguin's stern look. Later that evening, Van Gogh cut off his own ear lobe, wrapped it up neatly, and delivered the gift to a prostitute he often visited.

Lutsin, as well as other authors, has attempted to hypothesize about the reason Van Gogh committed such a violent act against himself. Whether this act reflected his self-punishment tendencies, pent-up libido, or perhaps even a symbolic attempt at auto-sterilization, it is a fact that this act caused concern amongst his neighbors, so they petitioned to have him committed to a psychiatric institution.

The last 2 years of his life included multiple hospitalizations for illnesses described as hallucinations, paranoia, insomnia, epilepsy, turpentine poisoning, and excessive sun exposure. During this time, his paintings were very expressionistic and full of symbols of death. Physicians have even noted that the halos present in many of his late works could be secondary to digitalis toxicity since his physician had prescribed this plant for Van Gogh's consumption.

In July 1890, on a Sunday morning, Vincent Van Gogh fired a bullet through his body and died just 3 days later while smoking and talking to his physician and his brother Theo.

Vincent Van Gogh led a very tragic life, and it is obvious that numerous biological, social, and psychological problems influenced his artwork. It is not necessarily important that we diagnose what mental illness afflicted him. I think it is only important that we appreciate that most of Van Gogh's best works of art were created during the most stressful periods of his life.

Medical student Macht's paper was written as part of the Physicians and Arts elective under Dr Leah Dickstein, faculty advisor in the Psychiatry and Behavioral Sciences Department at the University of Louisville.

Shackled by the System?

“We as physicians need to remain united and not allow ourselves to be fragmented by greed or fear.”

I was recently made aware of an article by Eric Chapman describing the similarities between prisons and hospitals. In an oddly amusing way the similarities are noticeable. In both cases the individual is given a number which becomes more important than his name, he is given special clothes to wear, he is assigned a room with a stranger unless he is dangerous to others thus requiring isolation, and visitation rights are restricted. Bernard Jaffe felt the similarities could be carried further, and these resulted in both institutions functioning poorly. These include “the common mission of healing and rehabilitation, underfunding and over regulation, undue pressure to shorten treatment time and the public assessment of their success in the press.”¹

Where does the physician fit into this picture? The sad realization is that we too are in prison. We now have provider numbers more important than our names, we need permission (precertification) to admit patients, and length of stay is predetermined by the diagnosis.

How did we allow such a

situation to arise? Like most things, it is probably multifactorial. Disinterest and greed have played roles, but probably most important is the management of our affairs by nonmedical personnel. How else can you explain the transition from doctor to health care provider or the change from patient to client. What are we to expect next — “user friendly” operating rooms?

There is certainly no easy solution to this problem, but it must begin with a genuine interest in our affairs outside of actual patient care. Ideally this would start at the medical school level with time devoted to early learning about the health care delivery system. Secondly, active participation on medical staffs, along with our state and national organizations, is vital. Lastly, we as physicians need to remain united and not allow ourselves to be fragmented by greed or fear.

William P. Hoagland, MD

1. Jaffe B. *Surgical Rounds*. 1991;14(11):961-962.
2. Chapman E. *Healthcare Forum Journal*. 1990;33(6):17.

FEBRUARY

23-28 — 23rd Family Medicine Review, Session I; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

MARCH

6-7 — 35th Annual Postgraduate Ophthalmology Symposium; Diabetes Mellitus: Ophthalmic Perspectives; Hyatt on Capitol Square, Columbus, OH. Contact: 800/492-4445.

21 — Kentucky Thoracic Society 37th Annual Scientific Conference on Pulmonary Disease (Mechanical Ventilation), Lexington, KY. Contact: 1/800/366-LUNG.

APRIL

10-12 — Sports Medicine for Physicians; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

24-25 — Contemporary Pediatrics for the Practicing Physician; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical

Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

MAY

1-2 — Annual Meeting, The Virginia Society of Otolaryngology-HNS; Boar's Head Inn, Charlottesville, VA. Contact: Donna Scott, 4205 Dover Rd, Richmond, VA 23221; 804/353-2721.

8-9 — Diabetes, Lipids and Obesity: Critical Assessment of Risk Factors; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

17-22 — 23rd Family Medicine Review, Session II; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

JUNE

1-3 — 60th Assembly of the Southeastern Surgical Congress, Westin Peachtree Plaza Hotel, Atlanta, GA. Contact: Roger Sherman, MD, 69 Butler St Southeast, #314, Atlanta, GA 30303; 404/221-0570.

AUGUST

8-14 — 11th Annual Scientific Meeting and Exhibition of the Society of Magnetic Resonance in Medicine; Berlin, Germany. Contact: SMRM, 1918 University Avenue, Suite 3C, Berkeley, CA 94704; 510/841-1899; FAX 510/841-2340.

SEPTEMBER

3-5 — Perinatal Medicine; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

25-26 — 5th Annual Rehabilitation Management for the Primary Care Physician; Radisson Plaza Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

OCTOBER

25-30 — 23rd Family Medicine Review, Session III; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

Your Membership is the Key to the Auxiliary's Success

The AKMA is a diverse group of over 1,000 individuals who share a common bond to the field of medicine — our marriage to a physician. When you join the Auxiliary your membership works for all of us: for our spouses, for organized medicine, and for our communities. More importantly your membership shows that you are an advocate for medicine.

The Auxiliary's mission is "To work in coalition with the KMA to promote quality health care and sound legislation." The state Auxiliary serves as the link between county and national auxiliaries to provide leadership training and support to physician families.

To achieve our mission, we must:

- Encourage recruitment and retention of unified membership from *all* KMA spouses.
- Participate in the political process.
- Provide information to counties on ways to meet community health needs.
- Provide leadership training opportunities.
- Support health education.

The only way we can effectively accomplish any of these objectives is to encourage *every* physician spouse to be an advocate for medicine and to join AKMA.

Your membership in the state and national auxiliary will help us

continue to support projects throughout the state, while keeping you informed about what is happening in medicine that affects both you and your spouse.

Our participation in the American Medical Association Auxiliary sponsored Leadership Training sessions and the assistance we received from the AMAA chairmen and committee members help us maintain a high standard of member services. The resources and program materials available for county presidents-elect at these confluences can only help to enhance our own county and state programs.

If you live in a county that does not have an organized auxiliary, I would encourage you to join AKMA as a member at large. I will be glad to visit with you and other physician spouses to help you become involved with the Auxiliary to the KMA.

Anyone who would like more information about the auxiliary can contact me.

Gloria J. Griffin (Mrs Larry P.)

First Vice President
8710 Oldbury Place
Louisville, KY 40222

Important dates to remember for all members of AKMA:

- February 19, 1992 — AKMA Day at the Capitol, Frankfort, KY
- April 21-23, 1992 — AKMA Convention, Owensboro, KY



“I will be glad to visit with you and other physician spouses to help you become involved with the Auxiliary to the KMA.”

Three New Officers Elected to KMA Board of Trustees

During the 1991 KMA annual House of Delegates meeting held in Lexington, three new officers were elected to serve on the Board of Trustees. KMA congratulates the following members on their election and thanks them for their valuable leadership.

Donald R. Stephens, MD, Ninth District Trustee, brings to the 1991-1994 Board of Trustees almost 30 years of experience as a practicing physician, 23 years as a Ninth District KMA Delegate, and several years as an Alternate Trustee. This background of clinical practice, blended with KMA knowledge, gives him an indepth perspective on organized medicine.

Dr Stephens' KMA involvement also includes the Committee on Community & Rural Health, including several years as its Chairman, and current service as Chairman of the Rural Kentucky Medical Scholarship Fund.

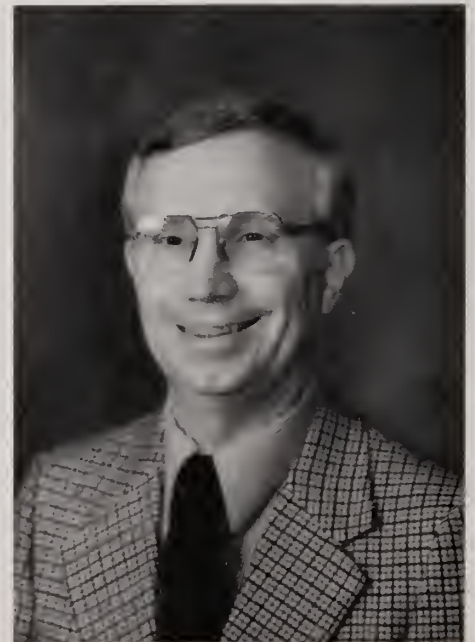
His dedication to organized medicine extends to various scientific and professional societies, including being a Fellow and Diplomate of the

American Academy of Family Physicians and membership in the Kentucky Academy of Family Physicians and the Southern Medical Association.

A family physician in Cynthiana, Dr Stephens, 58, earned an undergraduate degree from the University of Kentucky in 1956 and his medical degree from the University of Louisville in 1960. He completed an internship at St. Elizabeth Hospital in Dayton, Ohio. From 1967 to 1969, he served as a major in the US Army.

Dr Stephens is affiliated with Harrison Memorial Hospital in Cynthiana.

A native of Williamsburg, Kentucky, Dr Stephens and his wife, Sonia, live in Cynthiana. They have five children.



Ronald E. Walldridge, MD, was elected to serve a 3-year term as Seventh District Trustee.

A family physician in Shelbyville since 1969, Dr Walldridge, 51, earned his undergraduate degree from Georgetown College in 1962 and his medical degree from the University of Louisville School of Medicine in 1966. He served a rotating internship at Louisville General Hospital in 1967 with a subsequent term of military service as chief of staff for the US Public Health Service-Indian Health Service in Pine Ridge, South Dakota, from 1967 until 1969.

Long active in KMA, Dr Walldridge's involvement includes a 21-year term as a member of the Committee on School Health, Physical Education and Medical Aspects of Sports, serving 14 of those years as its Chairman. He has also served as a KMA Delegate and Alternate Trustee

for several years.

His dedication to sports medicine has carried over into the community with service as the team physician for Shelby County High School since 1969 and a 16-year term as Chairman of the Shelby County Board of Parks & Recreation.

Other professional and scientific memberships include Kentucky Academy of Family Practice, with past service as director and vice president, past president of Tri-County (Shelby, Henry, Oldham) Medical Society, American Academy of Family Physicians, Southern Medical Association, American Geriatrics Society, and American College of Sports Medicine.

Dr Walldridge is affiliated with the United Medical Center in Shelbyville.

A Jeffersontown native, Dr Walldridge and his wife, Sidney, live in Shelbyville. They have three children.



Gregory Cooper, MD, a Cynthiana family physician, was elected to serve a two-year term as Alternate Delegate to the American Medical Association.

Dr Cooper's KMA involvement includes several years of service on two committees he currently chairs — the Maternal and Child Health and Young Physicians Steering Committees, and the Scientific Program Committee. He has also served as a KMA Delegate representing the Ninth District.

Dr Cooper places great importance on his involvement with the Young Physicians Steering Committee and has served as both an Alternate Delegate and Delegate from KMA to the Young Physicians Section of AMA.

He began his medical career by

earning an undergraduate degree from Centre College of Kentucky in 1973 and his MD from the University of Louisville School of Medicine in 1978. He served a family practice residency at St. Michael Hospital in Milwaukee, Wisconsin, including one year as chief resident, and moved on to establish a family practice in Cynthiana and become a member of the active medical staff at Harrison Memorial Hospital.

In addition to clinical practice, Dr Cooper, 41, is active in various scientific and professional societies. He is a Diplomate of the National Board of Medical Examiners and the American Board of Family Practice.

A Louisville native, Dr Cooper and his wife, Deborah, have two children and reside in Cynthiana. *KMA*



PEOPLE

Leah J. Dickstein, MD, professor in the Department of Psychiatry and Behavioral Sciences and associate dean for faculty and student advocacy at the University of Louisville School of Medicine, was chosen president-elect of the American Medical Women's Association (AMWA) at their November 1991 annual meeting.

Dr Dickstein is a founder of the women's faculty group and has served as adviser to the U of L student AMWA branch. She co-founded the Association of Women Psychiatrists and has served as its secretary and president.

She is currently vice president of the American Psychiatric Association and also serves as co-chair of the Family Violence Advisory Group for the American Medical Association.

In addition to her research interests, which include a national study on stress, Dr Dickstein co-edited two books, "Women Physicians in Leadership Roles" and "Family Violence."

The American Medical Women's Association is the nation's largest organization of women physicians. Dr Dickstein will assume leadership at the association's annual meeting in San Francisco this coming November.

John S. Spratt, MD, a surgical oncologist at the James Graham Brown Cancer Center in Louisville, continues to be active in the battle against cancer on a national level. In December 1991, he was interviewed by the Jim French Talk Show at KIRO in Seattle, Washington, regarding progress that's been made toward the conquest of this disease since the passage of the National Cancer Act in 1971. Dr Spratt testified before the national panel of consultants on the conquest of cancer in 1970 and was at the White House for the signing of the National Cancer Act in 1971 by President Richard M. Nixon. He

subsequently was involved in the formulation of the national cancer plan under Dr Carl Baker, at that time director of the National Cancer Institute. Dr Baker was a former Louisvillian.

Dr Spratt was in Washington in September 1991 for the celebration of the 20th Anniversary of the Act, emphasized by special hearings held before Congress's Waxman's committee.

Dr Spratt pointed out that in his original testimony he stressed that major progress in cancer control would have to address prevention and the systematic application of extant knowledge in a cost effective manner to avoid a prohibitively expensive program that might totally miss the mark. He pointed out that progress has been made in the lymphomas and leukemias and the general understanding of the biology of cancer. However, because of the failure to pursue active prevention programs revealed in cancers such as lung cancer, it continues to increase its toll. He stressed that the time is not too late for prevention, but emphasis is long overdue. Dr Spratt stressed to Mr French that cancer is the most preventable and treatable of all chronic diseases, provided that effective programs are pursued.

Dr Spratt recently made a poster presentation entitled "The Risky Shift — Fallacies in Consensus Decisions" at the 25th Annual Convention of the American Association for Cancer Education (AACE) at the Johns Hopkins Hospital in Baltimore. He serves on the council of the society as the liaison for education between the AACE and the Association of the American Cancer Institutes. Dr Spratt is also the local arrangements chairperson for the 1994 meeting to be held in Louisville.

The U of L School of Medicine has announced the recent appointment of **Roland M. Puno, MD**, as an instructor in orthopedic surgery.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Barren

Sreejaya A. Reddy, MD — IM
Country Club Estates, Glasgow 42141
1974, Gandhi Medical School, India

Bell

Efren B. Valencia, Jr, MD — S
701 N 25th St, Middlesboro 40965
1970, Ramon Magsaysay, U of the East

Boyd

Michelle L. Bagley, DO — FP
132 Crestview Rd, Russell 41169
1979, Oklahoma Coll & Osteopathic Med

Dana A. Johnson, MD — HEM
1742 Dysard Hill Dr, Ashland 41101
1986, U of Kentucky

Clark

Stanley J. Hartanowicz, MD — U
205 Floyd Clay Dr, Winchester 40391
1974, U of Guadalajara

Fayette

C. Douglas Hensley, MD — D
177 Burt Rd, Lexington 40503
1986, U of Kentucky
Henry A. Stiene, MD — IM
151 Jesselin Dr, Lexington 40503
1986, U of Cincinnati

Greenup

Ben J. O'Dell, MD — IM
1150 St. Christopher Dr, Ashland 41101
1988, Marshall U

Graves

Charles E. Bea, MD — R
205 Duffers Ln, Mayfield 42066
1987, U of Kentucky

Henderson

Primilina A. Andres, MD — PTH
Henderson Co Mem Hosp, Henderson
42420
1969, U of Santo Tomas

Hopkins

Jibran E. Atwi, MD — A
Trover Clinic, Madisonville 42431
1985, American U of Beirut
Mark J. Fitzmaurice, MD — OPH
Trover Clinic, Madisonville 42431
1981, Georgetown U
John F. McGurrian, MD — S
Trover Clinic, Madisonville 42431
1982, Temple U
Joseph L. Milburn, Jr, MD — IM
Trover Clinic, Madisonville 42431
1984, U of Texas, Dallas
Janice Starsnic, MD — D
Trover Clinic, Madisonville 42431
1978, Jefferson Medical College
Jaroslav P. Stulc, MD — S
1200 College Dr, Madisonville 42431
1973, U of Iowa

Jefferson

James A. Breitwieser, MD — R
2330 Village Dr, Louisville 40205
1973, U of Minnesota
Mary Helen Davis, MD — P
10720 Hobbs Station Rd, Louisville
40223
1982, U of Louisville
Steven M. Eberly, MD — R
231 E Chestnut, Louisville 40232
1986, U of South Alabama
Stephen J. Kelty, MD — S
530 Audubon Medical Pl, Louisville
40217
1986, U of Louisville
Michael D. Kommer, MD — HEM
4003 Kresge Way, #111, Louisville
40207
1985, U of Louisville
Joseph A. Lash, MD — C
825 Barret Ave, Louisville 40204
1982, Indiana U

Knott

Piotr W. Olejniczak, MD — N
P O Box 849, Hindman 41822
1978, Academy of Med, Krakow,
Poland

Knox

David W. Habenicht, MD — EM
3015 Sapphire Dr, Corbin 40701
1984, Texas Tech U

Mason

Larien D. Kearns, MD — S
1340 Medical Park Dr, Maysville 41056
1982, U of Kentucky

McCracken

John F. Metcalf, MD — IM
RR 286 Box 249, Wickliffe 42087
1969, Northwestern U

Northern Kentucky

Vincent T. Bilotta, MD — OBG
20 Medical Village Dr #302,
Edgewood 41017
1987, U of Cincinnati
Christine Horner-Taylor, MD — PS
20 Medical Village Dr #335,
Edgewood 41017
1984, U of Cincinnati
Bradley G. Mullen, MD — NS
85 Kyles Ln, Fort Wright 41011
1985, U of Louisville

Oldham

Donald E. Belknap, MD — EM
Box 131, Goshen 40026
1983, U of Louisville

Pulaski

Ruben Nazario, MD — OBG
347 Bogle St, Somerset 42501
1974, U of Puerto Rico

Warren

David A. Campbell, MD — RHU
1724 Rockingham #301, Bowling
Green 42101
1986, U of Florida
James P. Kessler, MD — ORS
1611 Bent Tree Ave, Bowling Green
42102
1978, Ohio State

Eugene T. Tatum, MD — PTH
1617 Euclid Ave, Bowling Green 42103
1983, U of Colorado

New In-Training**Fayette**

Brenda Brotherton, MD — IM
Judy M. Linger, MD — P
S. Todd Robinson, MD — FP

Trover Clinic

Celina A. C. Atwi, MD — FP
Baretta Casey, MD — FP
David A. Francis, MD — FP
David W. French, MD — FP
Stephen C. Kareem, MD — FP
Michael W. Newkirk, MD — FP
Andrew J. Ninichuck, MD — FP
W. Deon Perkins, MD — FP

Jefferson

William B. Bradford, MD — R
St. Elizabeth's
James D. Wilson, MD — FP

DEATHS

Arthur F. Schultz, MD
Newport
1907-1991

Arthur F. Schultz, MD, a retired internist, died November 24, 1991. A 1932 graduate of the University of Cincinnati College of Medicine, Dr Schultz was a life member of KMA.

J. Samuel Bumgardner, MD
Louisville
1901-1991

J. Samuel Bumgardner, MD, a retired otolaryngologist, died December 7, 1991. A 1928 graduate of the University of Louisville School of Medicine, Dr Bumgardner was a life member of KMA.

Walter F. Beckett, MD
Bowling Green
1898-1991

Walter F. Beckett, MD, a retired general practitioner, died December 4, 1991. Dr Beckett was a 1928 graduate of Meharry Medical College and was a life member of KMA.

William C. Cheatham, Jr, MD
Louisville
1943-1991

William C. Cheatham, Jr, MD, a radiologist, died December 10, 1991. Dr Cheatham graduated from the University of Louisville School of Medicine in 1968 and was an inactive member of KMA.

Correction

In the December 1991 issue of the *Journal*, Danny M. Clark, MD, Somerset, was erroneously listed as Chairman of the Committee on Maternal and Child Health for 1991-92. J. Gregory Cooper, MD, Cynthiana, should have been listed as Chairman of this committee. Dr Clark remains a member of the committee but is no longer Chairman. We regret any inconvenience this might have caused.

CAGE Questionnaire

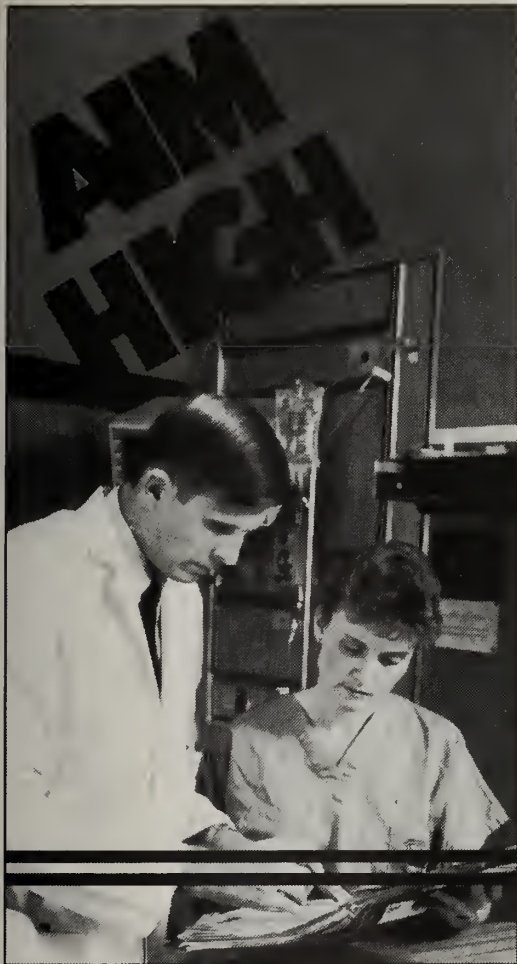
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- A** = Have people **annoyed** you by criticizing your drinking?
- G** = Have you ever felt bad or **guilty** about your drinking?
- E** = Have you ever had a drink first thing in the morning (**eyeopener**)?

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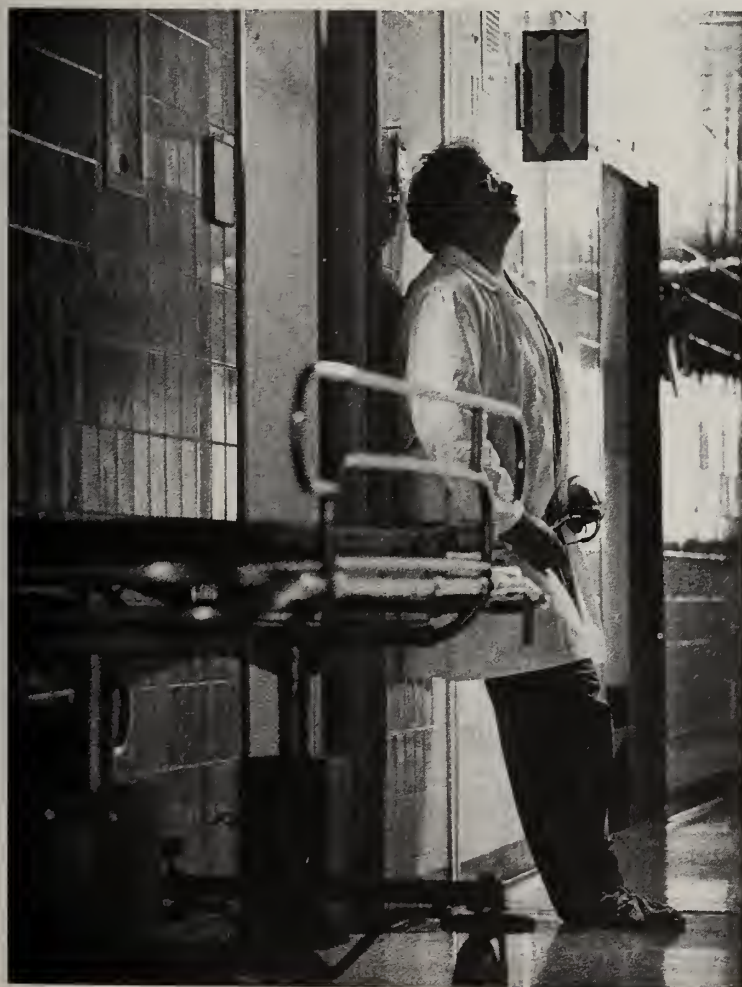
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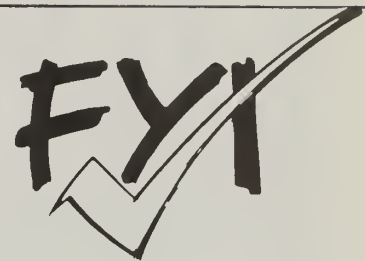
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Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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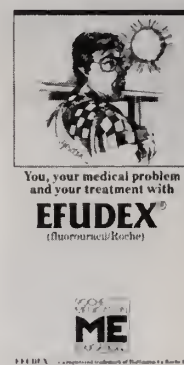
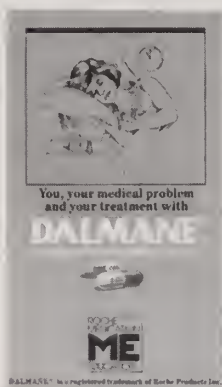
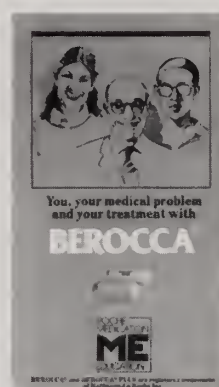
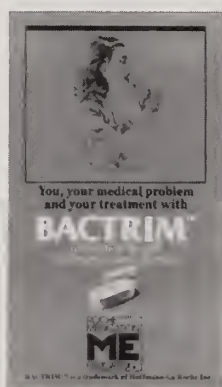


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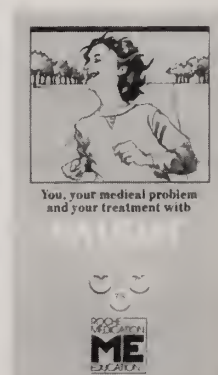
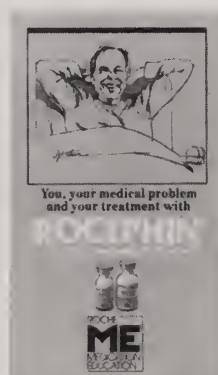
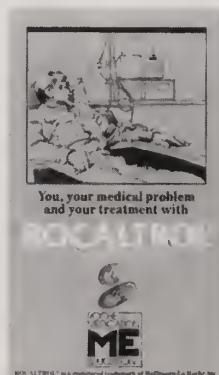
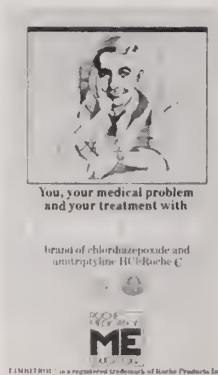
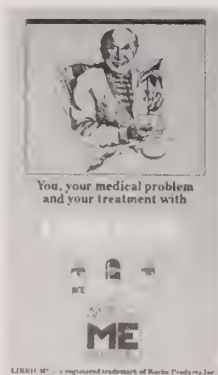
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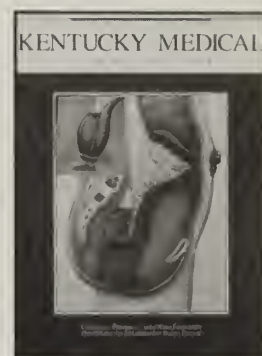


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VOLUME 90, NUMBER 3

MARCH 1992

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COVER: This superb anatomical drawing introduces an article on inflammatory bowel disease. See page 106.

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Is Anybody Out There?

Since the media first reported Senator Benny Bailey's proposal to tax physicians' gross receipts, freeze fees, mandate participation in Medicare, permit physician extenders to admit and prescribe without supervision, I have wondered if you received our mail or got the message. We asked you to contact your legislators and the Governor regarding Bailey's proposals. Quite frankly, we have been disappointed with the trickle of letters that have been generated. Many of the letters that have been written have been insulting ones to Senator Bailey rather than informative letters from physicians to their respective legislators. This is serious business as politicians' reactions and their vote are based solely on constituency interest. If they don't hear from you they assume you have no interest. On occasions, major legislation has been passed with only 10 or 15 letters or phone calls determining a particular legislator's position.

Secondly, full participation in the political arena will ultimately determine physician's fate. At a recent hospital medical staff meeting with state legislators and KMA, a friendly southern Kentucky Senator told physicians in the audience, "Doctors, they're saying mean things about you down on Main Street." It drew a laugh, but everyone knew what the Senator was referring to. We have become the most visible and favorite target of the media and physician-bashing is common. We make every effort to point out that only 19% of the health care dollar is reimbursed to physicians. We call attention to the fact that physicians have and will continue to treat indigent and Medicaid recipients, reaffirmed by the fact that over 2,300 physicians participate in Kentucky Physicians

Care. The 2,300 KPC participants, including the 1,100 primary care physicians, have made the difference in how Kentucky physicians are perceived. If you're not a KPC participant, you ought to be. This program is one of the most visible assets mentioned by legislators. In addition, the Kentucky Medicare carrier reports that over 80% of Medicare claims are accepted as paid in full by Kentucky physicians.

Full political participation requires that you get involved in the State legislative races and personally contribute. Participation also includes joining KEMPAC, the political arm of medicine. Less than 8% of physicians belong . . . that's pathetic . . . but it typifies the malaise in our profession. **The General Assembly is a full partner in state government with the Governor.** The shift of power has taken place with many observers believing that the General Assembly's power may even exceed the Governor. I understand the antipathy some of you have for politics. But that's no longer a valid reason or excuse when the creeping world of politics threatens to control access, delivery, and reimbursement for health care. **Whether we like it or not, it's hard ball time.** If you value the freedom to practice and the

"If you think RBRVS is bad, you should hear what some of the people in Frankfort and the legislature have in store for physicians."

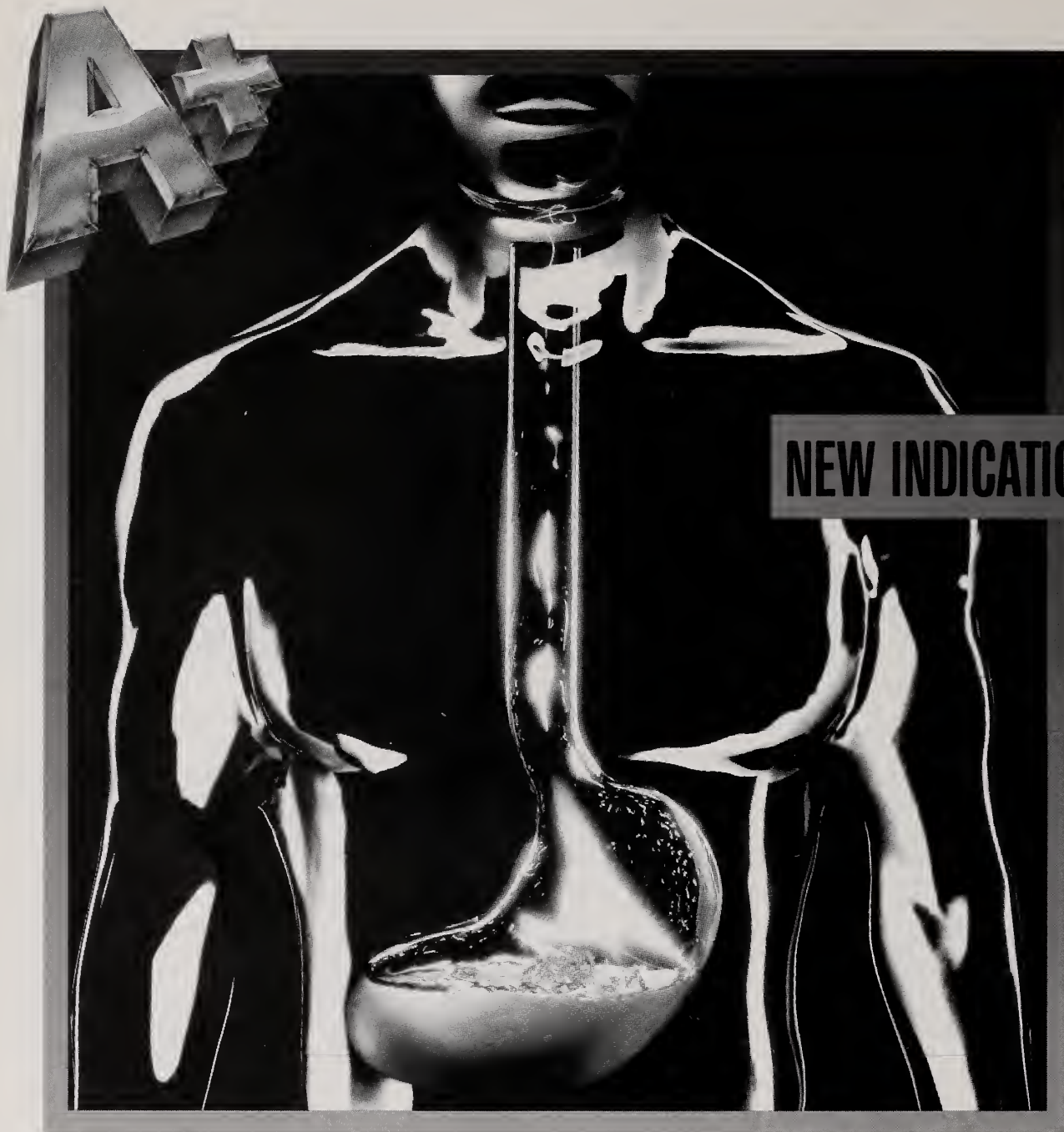


"Doctors, they're saying mean things about you down on Main Street."

ability to determine your own destiny, you'll get involved. If you think RBRVS is bad, you should hear what some of the people in Frankfort and the legislature have in store for physicians.

We are making every effort we can to represent you, but we can't go it alone. Remember . . . recommendations from the Governor's Blue Ribbon Task Force will be forwarded to the Kentucky General Assembly. The folks who will vote on these recommendations will be elected in the May 26 primary and the November 3 general election. If you don't know your State Representative and State Senator, you'd better get acquainted. Let me assure you that our adversaries will. Act accordingly.

Russell L. Travis
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Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H₂-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H₂-receptor antagonists.

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2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix[®] may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chloridiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, prenatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdose: Overdoses of Axid have been reported rarely. If overdose occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method. PV 2093 AMP

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

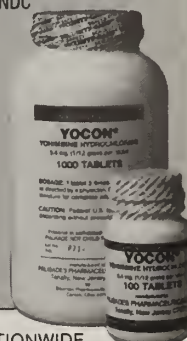
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

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Continence Preserving and Other Innovative Procedures for Inflammatory Bowel Disease

Susan Galandiuk, MD



Over the past 20 years, there have been major changes in the philosophy of treating inflammatory bowel disease. Significant advances include the development of continence preserving or sphincter saving procedures for ulcerative colitis patients and recognition of the need for bowel conservation in patients with Crohn's disease. Illustrative cases are presented followed by a brief description of state-of-the-art surgical management in these patients.

Introduction

Within the past 20 years, there has been a gradual change in surgical management of inflammatory bowel disease, accompanied by the development of several new procedures for the treatment of ulcerative colitis and Crohn's disease. These procedures include the continent Kock pouch and ileal pouch-anal anastomosis for patients with ulcerative colitis and strictureplasty in patients with Crohn's disease.

Crohn's Disease

Symptoms and Indications for Operation. The first clinical description of Crohn's disease was made by Crohn, Ginsberg, and Oppenheimer in 1932.¹ The authors described the disease as affecting the terminal ileum, involving subacute or chronic inflammation with ulceration of the mucosa, stenosis of the intestinal lumen and associated fistulae. Presenting symptoms in these patients are most frequently:

1. Abdominal pain, which can be secondary to obstruction, perforation, or abscess formation
2. Diarrhea, which may be due to partial obstruction
3. Weight loss due to protein-losing enteropathy and diarrhea
4. Growth retardation in children
5. The presence of external fistulae, eg, perianal or enterocutaneous fistulae.

The presenting symptoms in patients with Crohn's disease are dependent on the type and

extent of the disease. There are two basic patterns of Crohn's disease: obstructing versus fistulizing. In the former, the transmural ulcer will progress to perforation, abscess, and/or fistula. In the latter, the transmural inflammation will lead to progressive fibrosis with stenosis or stricture of the bowel lumen and obstruction. Crohn's disease can affect either the small bowel alone, both small and large bowel, the colon, or the perianal area.

The most frequent indication for initial operation in patients with small bowel Crohn's disease is obstruction.² In ileocolic Crohn's disease frequent indications for initial operation are obstruction and fistula or abscess formation. Obstruction is, therefore, a major indication for initial surgery in a large proportion of patients with Crohn's disease. Other indications for operation are: failure of medical therapy to adequately control the disease, intra-abdominal sepsis, enteric fistulae, toxic megacolon, and severe perianal disease. Severe perianal disease may improve with resection of intra-abdominal Crohn's disease but may require diversion and ultimately proctectomy.

Case Report

A 36-year-old white man with a 10-year history of Crohn's disease presented with symptoms of postprandial abdominal pain, nausea, vomiting, and weight loss. The patient had not had previous surgery and was being treated with 20 mg prednisone daily. Small bowel series revealed the presence of multiple short fibrotic strictures with interposed dilated small bowel (Fig 1). At exploratory laparoscopy, this was confirmed. The patient underwent Heineke-Mikulicz strictureplasties. His postoperative course was unremarkable and he could be discharged to his home on the 7th postoperative day with complete resolution of his obstructive symptoms. He continued to do well at last follow-up 2 years postoperatively, was still symptom-free, off prednisone, and had gained 20 pounds.

Surgical Treatment. The basic premise of surgical treatment is that Crohn's disease is a pan-intestinal disease; microscopic disease can be present

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Inflammatory Bowel Disease

Fig 1 — Short fibrotic small bowel strictures secondary to Crohn's disease, with interposed dilated small bowel.



in macroscopically normal-appearing bowel.³ About one-third of patients will require re-operation for recurrence within 11 years of their initial surgery.⁴ Accordingly, resection of large segments of small bowel can result in short bowel syndrome and should be avoided. The recurrence rate in patients who have undergone surgery for Crohn's disease at 10 years is over 30%.⁴ When operating on these patients one should therefore

treat only the specific complication for which surgery is required. Bowel should be conserved and unnecessary resection avoided; however, strictured or stenosed segments of bowel should not be left behind. Anastomoses should not be performed in the presence of gross sepsis.

Over the last 10 years, an increasingly large amount of experience has been gained with the technique of strictureplasty.^{5,8} This had originally been performed in India for the treatment of patients with small bowel strictures secondary to tuberculosis.⁹ Strictureplasty was first used by Emmanuel Lee¹⁰ in the late 1970s for patients with Crohn's disease. The procedure is similar to Heineke-Mikulicz pyloroplasty. A strictureplasty (Fig 2a) involves opening the antimesenteric side of the strictured bowel longitudinally and extending the opening 2 cm to 3 cm into normal bowel on either side. This can obviously only be done for relatively short strictures. The bowel is then closed in a transverse manner. A Finney-type strictureplasty is performed for longer strictures. The strictured area is opened longitudinally and the bowel is sewn together in a side-to-side fashion similar to a Finney pyloroplasty (Fig 2b). On small bowel follow-through, dilated loops of small bowel are interposed between strictures. At surgery, these strictures are very short, fibrotic, and the proximal bowel is grossly dilated. Fat wrapping and serositis are usually present. When the bowel lumen is opened in strictures areas, active Crohn's ulcers can frequently be seen in the mucosa of the mesenteric side. Postoperative relief of pain and obstructive symptoms is quite dramatic in this type of patient with obstruction due to short fibrotic strictures.⁶

Conservative surgery using strictureplasty can be performed successfully in selected patients. It is suitable in treating multiple short fibrotic strictures of small bowel and in treating single or multiple strictures after previous bowel resections. It can also be used in patients with extensive Crohn's disease who are at risk of developing short bowel syndrome. Complications such as fistula or bleeding from a strictureplasty site or restriction may occur, and the overall complication rate is approximately 14%.⁶ This is comparable to the morbidity following conventional resection for Crohn's disease and has the advantage that no bowel is removed. Over time, approximately 10% of patients develop new strictures at previously non-stenotic sites.⁶

Contraindications to strictureplasty include acutely inflamed bowel, free perforation or peri-

intestinal abscess, and a fistula arising from a strictured segment. Strictureplasty should not be performed close to a planned resection and should not be performed for multiple strictures in a short segment.¹¹ Strictureplasty has been shown to be safe in a large number of patients over time and shown to effectively relieve obstruction due to short fibrotic Crohn's strictures without bowel resection.

Ulcerative Colitis

Symptoms. Diarrhea, often mixed with blood, is the predominant symptom of ulcerative colitis. Patients can have up to 40 bowel movements a day. This is associated with abdominal cramps, tenesmus, weight loss, and fatigue due to anemia associated with blood loss. Extra-intestinal manifestations may occur as with Crohn's disease patients. The most significant extra-intestinal manifestations for the surgeon are sclerosing cholangitis, which can lead to portal hypertension and thrombocytosis in excess of 600,000 platelets/dl which can pose a significant embolic risk.

The extent of ulcerative colitis varies from disease limited to the rectum, rectosigmoid, left colon, or involving the entire colon (pan-colitis). Ulcerative proctosigmoiditis has a relatively good prognosis compared with pan-colitis. In nearly all of these patients, the disease remains localized and usually responds well to medical therapy such as steroid or 5-aminosalicylic acid (5-ASA or Rowasa®) enemas. The risk of cancer in these patients is almost nil compared with those with colitis affecting the entire colon. Of the 10% of patients with ulcerative proctosigmoiditis who progress to have colitis involving the entire colon, this usually occurs within 5 years of diagnosis.¹² Medical therapy in these patients includes the use of oral sulfasalazine, and, more recently, 5-ASA, which is the active component of sulfasalazine but is not associated with sulfasalazine-related side effects such as rash, headache, and arthralgia.¹³ Steroids, either oral or topical, are effective in controlling patients' symptoms and diphenoxylate and loperamide may provide relief from diarrhea.

Case Report

A 48-year-old white woman with a 6-year history of ulcerative colitis presented with complaints of fever, abdominal pain, and bloody diarrhea with up to 20 bowel movements daily. Following hospital admission, her symptoms failed to improve

despite high dose intravenous steroids, total parenteral nutrition, and bowel rest. She underwent abdominal colectomy, end ileostomy, and a Hartmann procedure. Postoperatively, she had a prolonged recovery but was discharged 1 month after operation. Six months following this surgery, she continued to complain of bloody drainage from her rectal stump despite steroid enemas and wished to be evaluated for ileorectostomy. Proctoscopy revealed active colitis with pus covering the mucosa, mucosal ulcerations, and bleeding upon touch. She was told that because of her significant rectal disease, functional results following ileorectostomy were likely to be poor, and she selected ileal pouch-anal anastomosis. She underwent this procedure with a temporary loop ileostomy which was closed 8 weeks postoperatively. Six months after ileostomy closure, the patient is now off steroids and has four bowel movements daily with good continence.

Indications for Surgery. In the past, recommendation for operation was limited by the fact that the only operations that removed all disease required a permanent ileostomy. Today, all disease can be removed while preserving good postoperative bowel function without an ileostomy. The indications for surgery have accordingly broadened. One of the major reasons for elective surgical treatment of ulcerative colitis patients is poor response to medical therapy, which includes growth retardation in children. The need for prolonged high doses of steroids is an indication for surgery because of the many severe steroid-associated side effects including diabetes, hypertension, aseptic hip necrosis, and cataract formation. With the availability of continence preserving procedures, patients should generally not be maintained on doses of prednisone in excess of 20 mg/day for longer than a 1-year period.

Unlike Crohn's disease patients, obstruction is usually not the major indication for surgery in ulcerative colitis patients. Severe extra-intestinal manifestations such as arthritis, skin and eye problems, and thrombocytosis frequently respond to colectomy.¹⁴ Surgery is also indicated in the presence of severe dysplasia on colonoscopic biopsy or, of course, in the presence of adenocarcinoma. Prior to 10 years of duration of disease, the risk of developing colon cancer in ulcerative colitis patients is not higher than the general population. After this time, however, the risk of carcinoma rises dramatically.⁴ Unfortunately, there are few adequate studies examining the risk of cancer

Inflammatory Bowel Disease

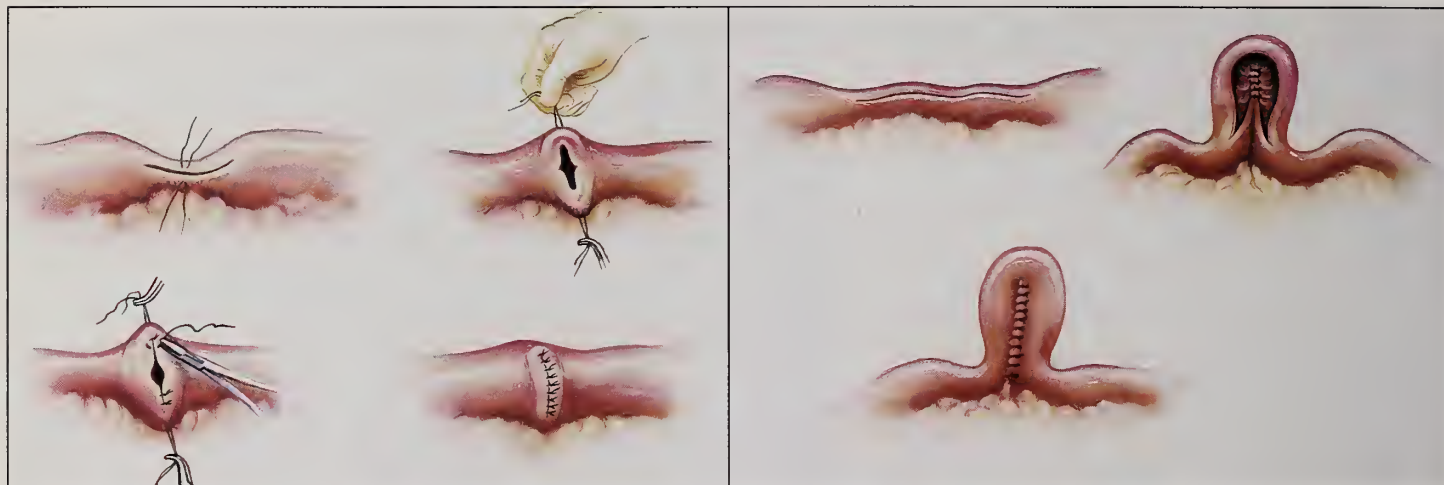


Fig 2 — Heineke-Mikulicz stricturoplasty (a). The strictured bowel is incised longitudinally extending for 1 cm into "normal" bowel, and the resulting enterotomy is closed transversely. Finney stricturoplasty (b). With longer strictures, the strictured bowel is incised longitudinally, and then closed side-to-side.

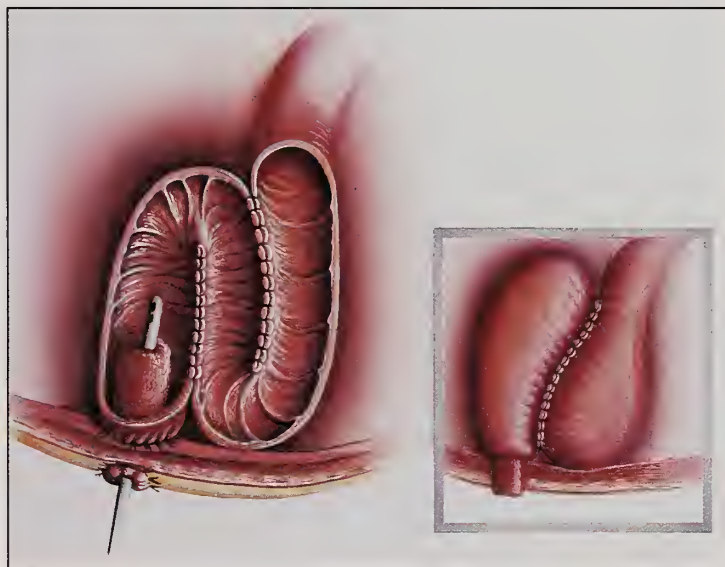


Fig 3 — Modification of Kock pouch²⁰ with S-shaped reservoir and nipple valve. Inset shows external appearance of pouch.

in these patients.¹⁵ Most studies are based on referral center populations which may not reflect the true incidence of cancer in all patients with ulcerative colitis. Some studies include patients with carcinoma at the time of referral and/or patients who have already had colectomy. Follow-up is

often incomplete. In addition, projections of the risk of cancer developing are based on a very small number of patients followed for a long period of time.

The basic reasons for serial surveillance colonoscopy in patients with ulcerative colitis who have disease of more than 10 years' duration is that the risk of cancer is not high enough to justify prophylactic colectomy in all patients but is too high to ignore. Key points regarding the surveillance for cancer in ulcerative colitis patients are that: (1) the clinical activity of disease is *not* correlated with the risk of developing carcinoma; (2) there is an increased risk of cancer developing even in asymptomatic patients; (3) the risk of cancer developing is related to duration of disease and is highest in patients with colitis affecting the entire colon as opposed to left-sided disease; and (4) since dysplasia is thought to be the first step in the development of cancer, colonoscopy with serial biopsy may detect patients with severe dysplasia who are at especially high risk of developing carcinoma. Prophylactic colectomy is frequently recommended in such patients. Problems with surveillance include determining if dysplasia is present. The pathologic diagnosis of dysplasia is difficult in the presence of inflammation or healing or regeneration of the colonic mucosa.¹⁵ Even among very experienced pathologists, there is a 4% to 8% inter-observer variation

in the diagnosis of dysplasia.^{15, 16} In addition, there is doubt as to how important dysplasia is. In one blinded study, distant severe dysplasia was present in only half of the ulcerative colitis specimens that had been resected due to the presence of colon cancer.¹⁷ This means that colon cancer apparently developed without associated severe dysplasia in half of the patients undergoing resection. There is approximately a 45% chance of unsuspected carcinoma being found in the resected specimen of patients with severe dysplasia undergoing colectomy.¹⁵ Such cancers in ulcerative colitis patients may present as plaque-like lesions, unlike typical colon cancers.¹⁸ In an analysis of four ulcerative colitis surveillance studies, unsuspected cancer was present in 27 of 73 patients who had severe dysplasia on colonoscopic surveillance.¹⁵

There is much debate as to exactly who needs a colectomy for ulcerative colitis. In the past, indications for surgery were somewhat limited by the unavailability of procedures which could avoid a permanent ileostomy. Today, it is clear that colectomy should be performed in severely ill patients not responding to medical therapy and in those patients requiring high maintenance steroid doses for prolonged periods. Notwithstanding the arguments above, the presence of severe dysplasia is a generally accepted indication for prophylactic colectomy. Colectomy in young patients with a very early onset of disease is controversial, since these patients have a very high cumulative risk of carcinoma developing over their lifetime. Many surgeons believe strongly that prophylactic colectomy should be recommended.

Surgical Treatment. The ideal operation in treating ulcerative colitis is one that eliminates all disease and avoids a permanent ileostomy. The four procedures most frequently performed for ulcerative colitis today include total proctocolectomy and Brooke (end) ileostomy, total proctocolectomy and Kock continent ileostomy, ileorectostomy and ileal pouch-anal anastomosis.

Advantages of a total proctocolectomy and Brooke ileostomy are that all disease is removed in a one-stage procedure with few complications. However, there may be delayed healing of the perineal wound. Patients who have a permanent ileostomy must wear an appliance.

Construction of the continent ileostomy of Kock is shown in Fig 3. Briefly, after total proctocolectomy is performed, a reservoir is made of

the terminal ileum and the distal portion of ileum is intussuscepted into this reservoir to form a continent nipple valve.¹⁹ When the reservoir is full, this acts as a flap valve and pressure on the outside of this nipple valve closes it so that the patient is continent. The patient empties this reservoir several times a day using a thin Silastic tube that is inserted into the ileostomy aperture and through the nipple valve. This operation removes all disease since a total proctocolectomy is performed. The patient has a continent ileostomy and no appliance is necessary. The procedure is, however, technically complex, and approximately 1 out of 5 patients will require reoperation due to complications such as "slipping" of the nipple valve.^{20, 21} The Kock pouch is not performed as frequently now as it was in the 1970s before other alternatives were available. It is suitable in patients who have undergone a total proctocolectomy and desire a continent stoma and in patients who are not candidates for ileal pouch anal-anastomosis due to poor anal sphincter function.

Subtotal colectomy with ileorectal anastomosis is a simple procedure associated with minimal complications. It does not, however, remove all disease since the rectum is left in place. Today, ileorectostomy has a rather limited role in the management of patients with ulcerative colitis since approximately 40% of patients will have poor functional results.²² There is an inability to accurately select good candidates for this procedure on the basis of preoperative endoscopy, and there is a 10% to 30% risk of proctitis and proctectomy at 4 years and an approximately 15% risk of cancer developing at 30 years.^{22, 23} Ileorectostomy is, however, still performed in patients who refuse permanent ileostomy but who are not candidates for either the Kock pouch or ileal pouch-anal anastomosis. It is also suitable in patients with primary sclerosing cholangitis and portal hypertension since construction of any type of stoma in these patients is associated with a high incidence of peristomal variceal bleeding. Ileorectostomy also plays a role in treating patients in whom there is serious doubt as to whether the diagnosis is Crohn's disease or ulcerative colitis.

Ileal pouch-anal anastomosis is currently the operation of choice in most patients with ulcerative colitis and familial adenomatous polyposis. An abdominal colectomy and proximal proctectomy is performed with stripping of the distal rectal mucosa. This eliminates all mucosal disease while preserving anal sphincter function. An ileal

Inflammatory Bowel Disease

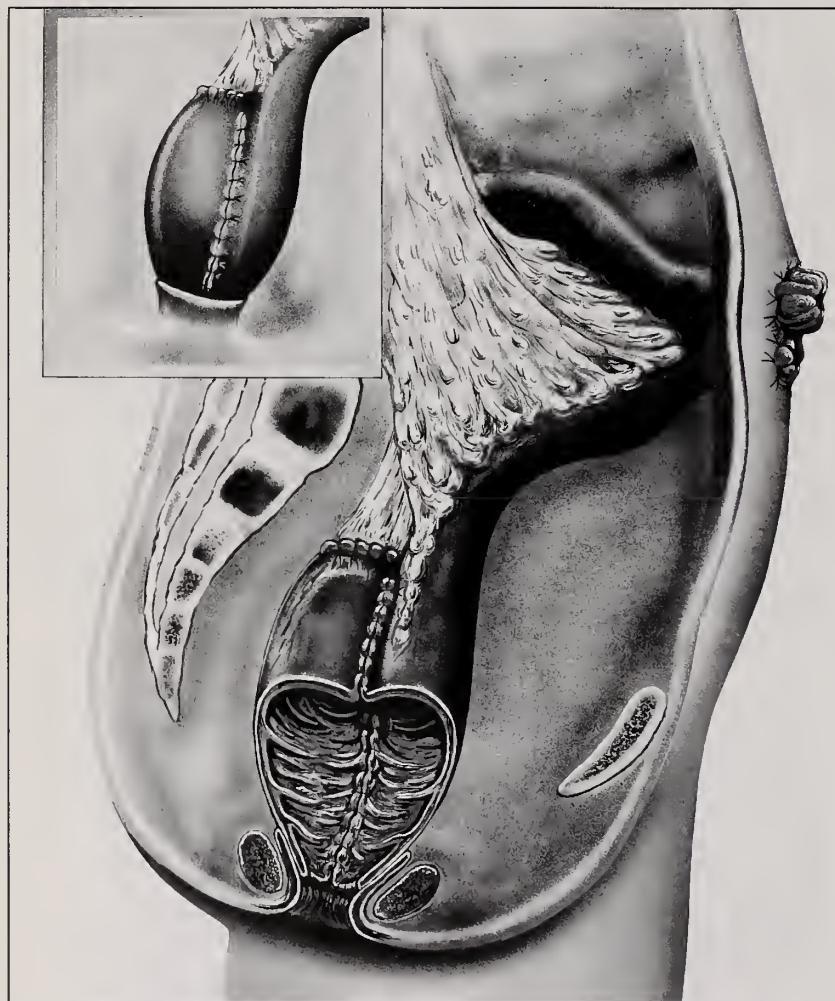


Fig 4 — Ileal J-pouch-anal anastomosis with cutaway view of ileoanal anastomosis. Inset shows external pouch appearance. This procedure is usually performed with a temporary loop ileostomy.

reservoir or pouch is created and is anastomosed directly to the dentate line (Fig 4). Due to the numerous suture lines that must heal, a temporary diverting ileostomy is usually performed in these patients and closed 6 to 8 weeks postoperatively. Construction of an ileal pouch restores the reservoir capacity of the rectum that has been removed and provides for intestinal continuity without the need for a permanent ileostomy.²⁴ There are many different types and shapes of reservoirs that can be constructed depending on the config-

uration of the small bowel. Most experienced surgeons prefer using a stapled J-pouch, since construction is simple and less time-consuming than larger hand-sewn reservoirs. The J-pouch provides for a compliant and propulsive reservoir with coordinated contractions and a reservoir capacity that is nearly that of a normal rectum.²⁴ The J-pouch also empties spontaneously; in other words, no catheter is required for the patient to defecate as has been reported for other types of reservoirs.^{24, 25} The largest series of this operation has been reported from the Mayo Clinic.²⁴ In their patient population, approximately 90% of patients undergoing this procedure had ulcerative colitis, with the remaining patients having familial polyposis. The overall mortality rate was 0.3%, illustrating the incredible safety of this procedure. Over 1,000 ileal pouch-anal anastomoses have been performed over the last decade. Major complications of this procedure include intestinal obstruction and pelvic sepsis. The risk of intestinal obstruction is no higher than that following total proctocolectomy. Postoperatively, most patients have an average of five bowel movements during the day and one at night. Although functional results in patients with ulcerative colitis are not as good as in patients with familial polyposis, ulcerative colitis patients are, however, able to control the time and place of defecation, unlike the urgency and diarrhea that they experience preoperatively.²⁶ Almost half of patients will take some type of fiber product or anti-diarrheal medication to increase the consistency of their stools.²⁴ Functional results improve significantly over the first postoperative year.

Of the four operations for ulcerative colitis described earlier, ileal pouch-anal anastomosis is the only procedure which removes all disease, preserves anal function, and avoids a permanent ileostomy. It is therefore the operation of choice in most patients with ulcerative colitis.

Summary

Surgical treatment of both Crohn's disease and ulcerative colitis have changed significantly over the past 20 years, with development of new surgical procedures, which in Crohn's disease preserves more bowel and in ulcerative colitis preserves anal sphincter function. In performing these procedures, proper patient selection is imperative. One must choose the best operation for an individual patient. With careful selection criteria, however, excellent results can be obtained.

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A Case of Tubo-Ovarian Abscess 6 Years After Hysterectomy

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Tubo-ovarian abscesses are uncommon complications from pelvic inflammatory disease. The theoretical basis for bacterial seeding of the Fallopian tube and ovary is an ascending infection through the uterus. This paper presents a case of a tubo-ovarian abscess in a woman 6 years after a hysterectomy. Although it is known that tubo-ovarian abscesses can occur in the presence of adjacent appendicitis or diverticulitis, neither of these was present in this patient. Therefore, the mechanism for infection in this patient was either a subacute condition preceding her hysterectomy or hematogenous seeding of her adnexal structures. Either of these mechanisms for infection challenge the currently held theories that have been put forth to describe the formation of tubo-ovarian abscesses.

Tubo-ovarian abscess is an uncommon complication of pelvic inflammatory disease (PID).

While it is recognized that PID can develop from extension of extrapelvic infections such as appendicitis and diverticulitis,¹ the primary mechanism of infection is thought to be due to bacteria invasion through the uterus. This paper presents a case of a tubo-ovarian abscess in a woman who had undergone hysterectomy and right salpingo-oophorectomy 6 years prior to her illness. In the absence of infections involving adjacent structures, this case suggests that mechanisms other than ascending infection may contribute to the development of pelvic inflammatory disease.

Case Presentation

The patient, a 39-year-old gravida 3 para 3 white woman who had undergone a hysterectomy and right salpingo-oophorectomy for fibroids with incidental appendectomy 6 years before the current illness, had been in excellent health and feeling

well until she presented to her family physician with a complaint of left lower quadrant pain and fever of 1 day duration without urinary symptoms or diarrhea. Examination of the patient at that time showed her to be in moderate distress with left lower quadrant tenderness, but no guarding or rebound tenderness. Her pelvic examination revealed no adnexal mass, and rectal examination showed normal heme-negative stool in the vault. A urinalysis at that time was negative and the patient was diagnosed with a presumed viral syndrome. A complete blood count was obtained along with a blood culture, and follow-up was arranged for the next day.

The following day the patient returned and was found to be febrile with a fever of 101.3°F and increased left lower quadrant tenderness. Again her rectal examination and urinalysis were normal. Her white blood count the previous day was found to be 21,300 with 85% granulocytes, 2% bands, and 12% lymphs. She was admitted to the hospital for evaluation of her pain, fever, and leukocytosis.

Other than her left lower quadrant pain and fever, the patient's physical examination was unremarkable. Her admission laboratory findings included a white blood count of 26,200 with 85% granulocytes, 9% bands, and 4% lymphocytes. Her hemoglobin and hematocrit were 14.0 gm/dl and 40.5%, respectively. A chemistry panel obtained on admission showed a sodium of 133 mmol/L, potassium of 3.3 mmol/L, and chloride of 97 mmol/L. Her blood urea nitrogen was 6 mg/dl. All other chemistry tests were normal. Her urinalysis showed 3 to 4 epithelial cells per high power field and no white or red blood cells. Electrocardiogram and chest x-ray were both normal.

A presumptive diagnosis of diverticulitis was made and the patient was started on intravenous cefazolin. The patient reported decreased pain after antibiotics were begun, and she had a reso-

lution of her fever within 48 hours. Her white blood count also began to normalize following institution of antibiotics, and by her fourth hospital day the patient was afebrile and had a white blood count of 9,600 with 68% granulocytes, 21% lymphocytes, and no band cells. The blood culture obtained the day before admission showed no growth.

While the patient was recovering, she underwent an evaluation for the source of her fever and leukocytosis. The day after she was admitted the patient underwent flexible sigmoidoscopy and barium enema which were both normal. An intravenous pyelogram was performed which showed no urinary obstruction or renal abnormality. An abdominal ultrasound was performed which showed a left sided abdominal mass extending to the umbilicus and of mixed solid and fluid content. This was confirmed by CT scan and presumed to be a left ovarian cystadenocarcinoma. A CA-125 test was performed and was found to be 14 (normal < 35).

On her fifth hospital day the patient was taken to surgery where a large cystic structure contiguous with the normal appearing left ovary was identified. No ascites was noted in the abdomen and no palpable lymph nodes were found. The mass was excised and the contents aspirated and sent for culture and cytology. Subsequent culture results demonstrated no growth, and cytology showed only mesothelial cells, lymphocytes, and granulocytes with no malignant cells identified.

Pathologic examination of the mass revealed a large cyst arising from the fallopian tube and filled with necrotic material and polymorphonuclear cells consistent with a large tubo-ovarian abscess. No malignant cells were identified in the cyst, fallopian tube, or ovary. Gram stain and fungal stains of the specimens showed no organisms.

The patient recovered from her surgery without incident and was discharged to home on the 10th hospital day. She subsequently was tested for tuberculosis with an intermediate strength PPD which was negative at 48 hours.

Discussion

This patient underwent a hysterectomy, right salpingo-oophorectomy, and appendectomy 6 years before the index illness, but apparently developed a tubo-ovarian abscess in the remaining left fallopian tube. Because she had previously undergone a hysterectomy, a tubo-ovarian abscess was

not originally considered in the differential diagnosis of her left lower quadrant and flank pain, fever, and leukocytosis. Her tubo-ovarian abscess was discovered by ultrasound and CT scan only after several other studies were negative. Fortunately, the patient was started on a broad spectrum antibiotic at the time of her admission to the hospital, so the delay in the diagnosis of her abscess apparently did not cause any adverse consequences.

A tubo-ovarian abscess following hysterectomy is extremely uncommon. Tubo-ovarian abscesses have been reported in the immediate post-operative period following vaginal hysterectomy,² but only one other case of a tubo-ovarian abscess has been reported several months after a hysterectomy. Stone and LaRose reported a tubo-ovarian abscess diagnosed 15 months after the patient underwent a vaginal hysterectomy.³ The case presented herein differs from previously reported cases in two ways: (1) the length of time that passed between the performance of a hysterectomy in this patient was much longer than in any other previously reported cases; and (2) all previous cases of post-operative tubo-ovarian abscesses followed vaginal hysterectomy, while this patient underwent an abdominal hysterectomy.

While PID and tubo-ovarian abscess most often occur secondary to an ascending infection through the uterus, it has been recognized that PID can occur via extension from nearby organ infections such as appendicitis and diverticulitis.¹ Additionally, hematogenous spread of infection has also been reported, although the only organism reported to infect the adnexal structures via a hematogenous route is tuberculosis. The patient in this report was found to have no evidence of diverticulitis and had undergone appendectomy with her hysterectomy 6 years prior to her illness. Furthermore, no evidence of tuberculosis infection was found either clinically, pathologically, or via tuberculin skin testing. This suggests that this patient's infection developed either by hematogenous spread or from bacteria that were present at the time of her hysterectomy. Either of these two possibilities challenges our current understanding of the etiology of pelvic inflammatory disease.

If this patient's PID and abscess were acquired through hematogenous bacterial seeding of her adnexal structures, this would imply that some cases of PID may not be ascending infections. Current theories to explain the etiology of PID hypothesize that the upper genital tract is inoculated with bacteria normally present in the

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lower genital tract either by a so-called "in-suck" mechanism,⁴ or bacterial piggy-backing on motile spermatozoa^{5,6} and trichomonads.⁴ Bacterial seeding of the adnexal structures via a hematogenous route secondary to transient bacteremia associated with coitus could also serve as a mechanism of PID development. While transient bacteremia with intercourse would not be anticipated routinely, in patients with severe cervicitis or erosive vaginitis it is possible that intercourse could cause a transient bacteremia. This would help explain why many cases of PID are polymicrobial in nature^{7,8} and why PID can be observed in some pregnant women when it is assumed that cervical mucous thickening would prohibit the ascension of bacteria into the upper genital tract.⁹

On the other hand, the patient described in this report may have had bacterial seeding of her adnexal structures prior to her hysterectomy, and the current pelvic abscess may have occurred after a prolonged subclinical stage of infection. This was the presumed nature of infection in the previously reported case of pelvic abscess several months following a hysterectomy.³ In that case the patient was actually treated with antibiotics for 6 weeks after her surgery for presumed cuff cellulitis. However, the patient described in this report had no peri-operative complications. In the unlikely event that this patient's tubo-ovarian abscess is due to reactivation of prior bacterial seeding via the uterus, the bacterial seeding of the adnexal structures would have had to precede clinical PID by many years. This mechanism suggests that organisms may remain in the adnexal structures for prolonged periods without any sign of infection.

In conclusion, the development of PID and an adnexal abscess 5 years after a hysterectomy suggests that a reexamination of the currently held concepts regarding the etiology of PID is in order. Either hematogenous spread of vaginal organisms to the adnexal structures or a long dormant infection could explain the etiology of this patient's infection. It is unclear how commonly these mechanisms contribute to the development of PID in other patients. Nevertheless, even in patients who have previously undergone hysterectomy, a tubo-ovarian abscess needs to be considered in the differential diagnosis of lower quadrant pain, fever, and leukocytosis in a woman who has a remaining fallopian tube and ovary.

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Respiratory Complications of Renal Infection

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We present a case report of pleural effusion and hypoxia developing in a nonpregnant woman with a renal abscess. Our review of the literature reveals that the other reported cases of respiratory complications of renal infections have all occurred in pregnant women.

Introduction

Respiratory complications of renal infections have been reported infrequently, and then only in association with pregnancy.^{1,5} We report a case of left renal abscess and left pleural effusion and hypoxia in a young nonpregnant woman.

Case Report

A 29-year-old woman was treated with Amoxicillin as an outpatient for what was at least her seventh urinary tract infection over the previous 12 years. This was manifested by dysuria, increased frequency, and pyuria without fever when seen, though she claimed to have had a low-grade fever over the past 2 months. The urine culture, as with all six of her previous urinary tract infections, revealed greater than 100,000 bacteria per cc of *Escherichia coli* sensitive to ampicillin.

She was referred within 2 days to a urologist who found her to have a white blood count of 18,300 cells per mm³ with mild shift to the left, hematocrit of 43%, and hemoglobin of 15.1 gm/d. An intravenous pyelogram with nephrotomography was normal.

Five days after her initial visit she presented with left mid-abdominal tenderness and temperature of 38.7°C orally but without dysuria or increased frequency. She was referred to a surgeon and admitted. Urinalysis revealed +1 proteinuria, trace hematuria (she was having her menstrual period at this time), and 10-12 white blood cells per high power field. Quantitative urine culture

was positive for *E. coli* (which was now resistant to ampicillin) with 100,000 bacteria per cc. Two blood cultures were negative, and the patient had no rigors or shaking chills. Hematocrit was 39%, hemoglobin 13.2 gm/d, and there were 22,100 white blood cells per mm³ with 80% polymorphonuclear cells, 1% stabs, and 19% lymphocytes. Blood urea nitrogen was 5 mg/d, creatinine was 0.8 mg/d, and electrolytes were normal. ALT was 19 and 39 IU/l on two determinations; GGT was 109 and 236 IU/l on two determinations; while bilirubin was 0.5 and 1.0 mg/d on two determinations. Serum albumin was 3.9. Admission chest radiograph was normal. A computed tomographic scan of the abdomen showed a 3.5 cm thick-walled hypodense mass in the upper pole of the left kidney. This was also confirmed by renal ultrasound. Gallium scan showed this mass to be inflammatory in nature. She was treated with ampicillin/sulbactam 1.5 gm IV every 8 hours.

On the third hospital day, a repeat chest radiograph, including a left lateral decubitus film, showed a small left pleural effusion without underlying infiltrates, for the first time. She continued to have a febrile course with temperature spikes to 39.2°C orally in the late afternoons and underwent incision and drainage of a left renal abscess on the 8th hospital day. Culture of this drainage revealed *E. coli* resistant to ampicillin.

Postoperatively, she was noted to be cyanotic. Arterial blood gas on room air showed a Po₂ of 49, Pco₂ of 43, and pH of 7.38. With supplemental nasal oxygen, her Po₂ rose to 76 while Pco₂ was 45 and pH was 7.38. She denied dyspnea. A portable chest radiograph suggested a left pleural effusion, which was subsequently confirmed with decubitus films of the chest. She continued to have a low-grade febrile course with temperatures to 38.3°C orally. Four days postoperatively, a left thoracentesis was done, removing 430 cc of serous fluid with 260 red blood cells per mm³, 2,000

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white blood cells per mm^3 , with 42% polymorphonuclear cells and 58% mononuclear cells. The protein of this fluid was 390 mg/d, while glucose was 109 mg/d, and amylase 39 IU/l. Culture of this fluid was negative. Followup chest radiograph revealed the left lung field to be clear.

Thereafter, she had no further fever and noted less malaise. She was discharged and had an uneventful recovery. One month after her hospitalization, her Po_2 was 87, Pco_2 was 35, and pH was 7.44 on room air. Her urine pregnancy test was negative.

Discussion

We have reported a case of transudative pleural effusion and hypoxia as a complication of a renal abscess in a nonpregnant woman. There are a number of reports of pulmonary complications of pyelonephritis in pregnant women.

Pruett and Faro¹ report on a case of transudative pleural effusion complicating pyelonephritis in a pregnant woman. They conclude that "respiratory distress developing in patients with pyelonephritis has not been reported in nonpregnant women."

Cunningham et al² reported on four cases of respiratory insufficiency associated with pyelonephritis in association with pregnancy. Three of their patients had pulmonary infiltrates and pleural effusions. The fourth patient had pulmonary infiltrates only. All four patients were hypoxic. They suggest an endotoxin as the etiology for the respiratory problems as well as for the hemolytic anemia, mild liver enzyme elevation, and loss of hypothalamic temperature control which they observed in their patients. They noted that "to the author's knowledge, pulmonary dysfunction associated with pyelonephritis has not been reported in nonpregnant patients."

Three years later, Cunningham et al³ reported again on their 4 patients plus 11 additional pregnant women with acute pyelonephritis and respiratory insufficiency. Nine of their 15 total patients had uncharacterized pleural effusions. All had pulmonary infiltrates and were hypoxic. Those who had pulmonary artery catheterizations had normal findings. They felt that this was probably caused by "permeability pulmonary edema, likely mediated by endotoxin-induced alveolar-capillary membrane injury since other evidence of endotoxemia was common."

A single case report by Soisson et al⁴ presented a pregnant woman with hypoxia and pul-

monary infiltrates. They also concluded that, "respiratory insufficiency appears to result from circulating endotoxin, a complex lipopolysaccharide." They suggested that this endotoxemia led to inflammatory injury of the alveolar and capillary endothelium which led to increased capillary permeability and transudation of fluid into the interstitial spaces.

Also, Elkington et al⁵ reported on a pregnant woman with adult respiratory distress syndrome and pyelonephritis. They considered four possible causes of the adult respiratory distress syndrome in their patient: (1) iatrogenic fluid overload, (2) inappropriate use of terbutaline, (3) decreased plasma osmotic pressure, and (4) endotoxin mediated events. They suggested that all of these factors may have played a role in their patient.

Renal abscess is an infrequent complication of recurrent urinary tract infections. However, pleural effusion and hypoxia are not previously reported complications of a renal abscess in a nonpregnant patient. It should be noted that the pleural effusion in our patient was first observed several days prior to the surgical procedure; thus, it cannot be explained simply as a complication of her left renal incision and drainage.

Of the possible causes that others have considered for the respiratory complications of renal infections, fluid overload seems unlikely in view of our patient's normal renal function, and lack of excessive intravenous fluids (2400-2950 cc per 24 hours). Terbutaline was not used, and with normal electrolytes, it does not appear likely that decreased plasma osmotic pressure played a role. This leaves us with the possibility of endotoxin related causes.

Suffredini⁶ has noted that intravenous endotoxin administration and volume infusion in normal human volunteers caused decreased arterial oxygenation and increased alveolar permeability.

In a study done in pigs by Olson et al⁷ increased leukotriene B₄ was found in the bronchoalveolar lavage fluid and plasma in those in which endotoxin was infused. This endotoxin infusion resulted in the development of pulmonary edema and increased permeability of the alveolar-capillary membrane. These authors suggest that leukotriene B₄ could possibly be an important factor in contributing to the pathophysiology of endotoxin-induced acute respiratory failure.

Our case report represents an exception to all of the other existing case reports in that our

patient was not pregnant. However, the persistence of her infection, despite antibiotic coverage, and the development of a renal abscess resulted in a more pronounced and prolonged infection, the severity of which may have contributed to this complication. If endotoxemia is to be postulated, then the severity of our patient's infection may have been the reason why she developed this complication despite not being pregnant.

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Recognition of Upper Airway Obstruction Misdiagnosed as Asthma

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Distinguishing new onset asthma from an insidious upper airway obstruction can prove difficult and is more frequently being addressed in the medical literature.^{1,2} We examine our experience in a teaching hospital and analyze the problems relating to establishing the correct diagnosis.

Introduction

Patients with the gradual development of upper airway obstruction (UAO) may initially be misdiagnosed as having hyper-reactive airways disease. In addition to the delay of definitive treatment for a more serious problem, the patient may experience exposure to potentially dangerous medications used in the maximal treatment of refractory asthma.

The presence of stridor has traditionally been the herald sign of upper airway problems, but it has been pointed out that stridor is not clearly defined in many physical diagnosis textbooks.³ The implications of this physical finding are subsequently not always fully appreciated by the clinician.⁴ Since UAO may occur in patients with true underlying asthma, the importance of recognizing the presence and significance of concurrent stridor cannot be overemphasized.

We review those features that have proved helpful in distinguishing UAO from new onset asthma in our situation and review the information currently provided by other investigators addressing this same problem.

Patients and Methods

Forty-two adult individuals were identified by computer retrieval methods as having a confirmed diagnosis of UAO during the most recent 5-year interval at our teaching institution. The medical record of each patient was reviewed for

patient demographics, mode of presentation, initial working diagnosis, methods of establishing the diagnosis of UAO, and the etiology of the UAO.

There were 23 males and 19 females. Fig 1 shows the distribution of the causes of UAO. Five of the 42 individuals (12%) were initially thought to have new onset asthma and were treated with aminophylline, beta-2 agonists, and corticosteroids. After hospitalization, the mean delay in reaching the proper diagnosis of UAO for these patients was 13+6 days. Unfortunately, these same five patients had premonitory complaints that suggested UAO for a mean interval of 4+2 months, during which time they were treated for hyper-reactive airways disease. Each of these individuals were young enough to have new onset asthma as part of their differential diagnosis. Each patient had experienced a gradual onset of dyspnea and inspiratory wheezing. It is this group of patients that are the basis for our discussion and concern. The remaining patients with UAO usually had some ancillary history or physical findings that directed the clinician to consider UAO immediately.

History of sudden onset of dyspnea, wheezing, and cervical discomfort for the first time helped with correct diagnosis of UAO in the three patients with inhalation of a foreign body. All three were radio-opaque and identified on radiographs. A dental appliance, a garbage bag tie, and a chicken bone were removed without difficulty.

History of trauma and/or smoke inhalation exposure aided in the correct diagnosis of UAO in nine patients with stridor. The presence of fever and nonproductive harsh cough accompanied by close scrutiny of the oropharynx allowed correct identification of 10 patients whose UAO was associated with infection.

Fifteen patients had UAO from the presence of head and neck cancer. Some of these patients

had been previously diagnosed with their tumor, while others presented with additional physical signs of facial, neck, or lymph node abnormalities which directed attention to the possibility of neoplastic involvement of the airway.

We must recognize that our study is limited by the retrieval methods employed. There may well have been UAO patients who were not correctly diagnosed and escaped identification by computer. Some of these individuals may have been discharged with the diagnosis of asthma and sought treatment elsewhere.

Discussion

The symptoms of UAO may be nonspecific, but generally include dyspnea and inspiratory adventitious sounds of a continuous "musical" nature, often referred to as stridor. The sound characteristics of stridor have only recently been analyzed scientifically and are known to emanate from turbulent airflow through a critically narrowed airway lumen. The turbulence is accentuated by any maneuver that increases airflow such as hyperventilation or forced inspiration. Generally the airway diameter must be decreased to 5 mm before stridor will be present during the resting respiratory cycle. Exercise and hyperventilation can produce stridorous sounds when airway diameter is reduced to 8 mm.⁵

Investigations of the adventitious sounds in patients with UAO or asthma have demonstrated that the sound frequency is remarkably similar,³ explaining some of the difficulty experienced by clinicians. Distinguishing stridor associated with UAO from inspiratory wheezing of asthma is critically dependent on attention to the timing of the sound and location of its intensity.³

Stridor is centrally located over the neck with prominence during inspiration. Additional inspiratory findings over the chest wall are less intense and are radiated sounds from the central airway. Inspiratory wheezing that may occur with asthma occurs more intensely over the chest wall and is almost always accompanied by expiratory adventitious sounds which are always of longer duration than the inspiratory sound.

Some patients with UAO experience hoarseness,odynophagia, and excessive drooling. A nonproductive barking cough is frequently associated by clinicians with UAO of an infectious nature. An often overlooked but important clue to the presence of UAO is the occurrence of such symptoms only when the patient assumes certain

Patients diagnosed with UAO

- 15 patients with head and neck cancers.
- 10 patients with infectious sources such as epiglottitis, pharyngeal abscess, tonsillitis.
- 5 patients who suffered severe smoke inhalation.
- 4 patients with trauma to mouth, tongue, or trachea.
- 3 patients who aspirated foreign bodies.
- *1 patient with subglottic stenosis from Wegener's granulomatosis.
- *1 patient with tracheal papillomatosis.
- *1 patient with tracheal compression by retrosternal thyroid enlargement.
- *1 patient with subglottic obstruction from AIDS related Kaposi's sarcoma.
- *1 patient with CLL with subglottic granuloma.

*Those patients misdiagnosed as asthma

Fig 1

positions.⁵ Chest wall pain, usually a feature absent in hyper-reactive airways disease, is often described by patients with UAO secondary to neoplasm or the presence of a foreign body.

Careful examination of the oral pharynx is mandatory if stridor is suspected. Such an exam will frequently reveal structural abnormalities or the presence of infectious processes. Indeed, in our study group no infectious etiologies of UAO were misdiagnosed as asthma.

With the advancement of computerized technology, the flow-volume loop has emerged as the single best test for detecting UAO and differentiating it from hyper-reactive airways disease. This pulmonary function test requires a cooperative patient and specialized equipment that is often not affordable for office use. Flow-volume loops are generally performed in hospitals and referral centers. The flow-volume loop can assess the presence and severity of a UAO and follow the patient's response to treatment. When airflow is plotted against volume, a flow-volume loop inscription indicating a UAO is the appearance of a plateau or limitation of airflow. This plateau may occur during the inspiratory and/or expiratory maneuver depending on the location and nature of the UAO. Importantly, peripheral airway obstruction associated with asthma or bronchospasm has an entirely different airflow inscription making the diagnosis considerably more precise for the practitioner.

The flow-volume loop inscription is determined by the physiology of the upper airway and

Upper Airway Obstruction

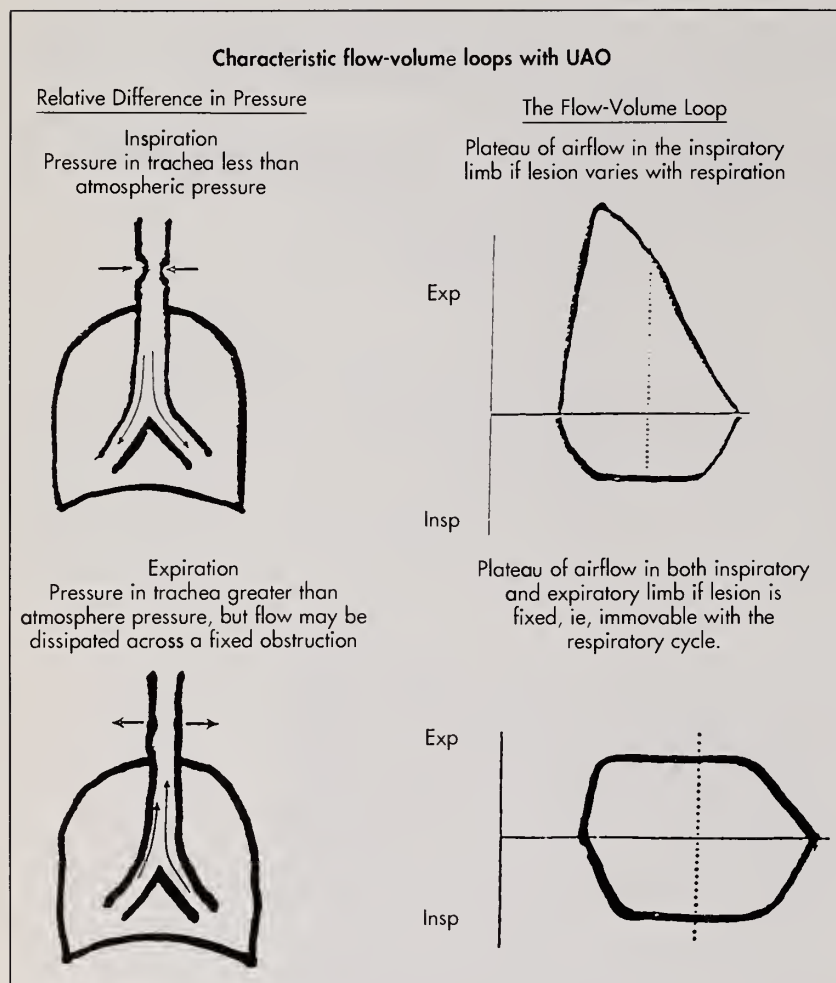


Fig 2

the effects of relative pressures in the trachea compared to atmospheric pressures during the respiratory cycle. The plateau in the inspiratory limb of the flow-volume loop results in a reduction in inspiratory flow rate due to loss of driving pressure across the obstruction combined with negative intrathoracic and intratracheal pressure (relative to the atmospheric pressure) leading to collapse of the trachea and increased tracheal resistance to flow. Fig 2.

While the value of the flow-volume loop has been well established in the diagnosis of UAO versus asthma, the contribution of routine spirometry should not be overlooked since the capacity to perform flow-volume loops may exceed the capabilities of most office spirometers. Many indices of routine spirometry have been noted as helpful to the clinician in suggesting the presence

Clues to UAO from the routine spirogram

- MIF less than the MEF
- FIF25-75/FEF25-75 less than 1
- MVV/FEV1 greater than 25 units
- FEV1 PEFR greater than 10 units

See text for abbreviations

Fig 3

of a UAO. While no single parameter identifies the patient with UAO, easily derived ratios of the standard measured spirometric indices help recognize patients likely to have upper airway obstruction.⁶ Fig 3.

For the physiologic reasons mentioned above, in UAO the maximum inspiratory flow rate is expected to be reduced more than the maximum expiratory flow rate. Those spirometric indices that require maximal inspiratory flow, including maximum voluntary ventilation (MVV), forced inspiratory volume in 1 sec (FIV1), forced inspiratory vital capacity (FIVC), forced inspiratory flow between 25% and 75% of the vital capacity (FIF 25-75), are expected to be abnormal in patients with extrathoracic UAO.

The ratio of maximum voluntary ventilation to forced expiratory volume in 1 second (MVV/FEV1) of less than 25 correctly identifies 67% of patients with UAO. An FIF 25-75/FEF 25-75 of less than 1 correctly identifies 80% of the patients with UAO. All patients with UAO in one study⁶ had one of these two ratios abnormal.

If a UAO is fixed (the lumen does not vary with the respiratory cycle) the peak expiratory flow rate (PEFR) is reduced because the positive intrathoracic pressure required for airflow at high lung volumes is dissipated across the obstructing lesion. A disproportionate decrease in the PEFR occurs when compared with the FEV1. The ratio of FEV1/PEFR can also be useful in separating upper from lower airway obstruction.⁷ From the information obtained from these simple forced expiratory maneuvers, this ratio can easily be calculated in the office. If the index is greater than 10, UAO is likely to be present and higher values are associated with greater degrees of obstruction. While the reductions in FEV1 and PEFR are proportional in asthmatics, those patients with lower airway obstruction have a FEV1/PEFR ratio

that is usually less than 10.^{7,8}

Radiographic studies may be helpful in the differential diagnosis of UAO and asthma, particularly when the obstruction is suspected to be due to a mass lesion or a foreign body. Soft tissue radiographs of the neck have proved helpful in establishing the presence of foreign body aspiration.⁹ These roentgenograms focus on narrowing of the subglottic airway and poorly defined radiodensities within the narrowed lumen. While metallic foreign bodies are obvious, the cervical roentgenograms of nonmetallic foreign bodies may suggest a homogeneous mass that makes the subglottic area more difficult to visualize than usual.

The addition of tracheal tomograms dramatically increases the yield if rapid spot films of the upper airway are inconclusive. Fluoroscopy may also demonstrate the signs of upper airway obstruction during the inspiratory and expiratory cycle. With inspiration, there is a prominent overinflation of the hypopharynx with narrowing of the trachea below the obstruction. During expiration, the trachea will become more distended while the hypopharynx usually collapses. Both tomography and fluoroscopy are useful adjuncts in the detection of minimally radio-opaque foreign bodies and masses causing UAO.

Radioscintigraphy has also been recommended when a localized UAO is suspected.¹⁰ This technique incorporates the inhalation of a radioactive aerosol while images of the neck, mediastinum, and lungs are obtained. Deposition of the radioactive aerosol in the airways will appear as hot spots. These will occur when reductions in the diameters of the airways produce abnormal air flow due to turbulence or eddy currents as high velocity air streams across stenotic sites. When comparing patients with proven UAO due to laryngeal tumors, strictures, and bronchogenic carcinoma invading the hilum and compressing one or both main bronchi to asthmatic patients who served as controls,¹⁰ characteristic patterns of radioactive aerosol deposition were established that could reliably differentiate the two disease states. In UAO, aerosol images demonstrated hot spots in the neck or mediastinum which corresponded to the sites of severe airway obstruction that were verified by tomography and bronchoscopy. In patients with bronchial asthma, however, multiple hot spots were demonstrated in the hilar areas of both lungs indicating partial obstruction of the more distal lobar and segmental bronchi. This technique serves well in detecting airway

obstruction caused by radiolucent aspirated foreign bodies.

When compared to tomography and bronchography, radioscintigraphy is more useful in differentiating acute asthma from UAO. Although tomography may confirm upper airway obstruction, it is unable to demonstrate diffuse peripheral airway obstruction. Bronchography will diagnose obstruction in more distal airways, but should not be performed routinely in asthmatic patients with heightened hyper-reactive airways prone to bronchospasm and laryngospasm.

Because the presence of stridor has connotations of a disease process with potentially greater risk to the patient than bronchospasm, clinicians must be aware of the subtleties that allow differentiation from the generalized wheezing of asthma. The measures mentioned above are particularly important in certain high risk groups which would include the elderly with asthmatic bronchitis who have the potential for developing neoplasm in the upper airway, the young asthmatic with a UAO from infectious processes, and youngsters with a high propensity for inhaling foreign bodies. The ancillary diagnostic tools should be employed in the newly diagnosed "asthmatic" who does not appear to respond to conventional maximal therapy or whose prominent symptom is persistent upper airway adventitious noise.

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Summary of Actions AMA House of Delegates Interim Meeting

The delegates considered 90 reports and 214 resolutions on a wide variety of national issues affecting physicians in the United States.

The AMA House of Delegates met December 8-11, 1991 in Las Vegas, Nevada.

There were 442 credentialled delegates representing 54 states and territories, 81 national medical specialty societies, 5 special sections, and 5 government services.

The delegates considered 90 reports and 214 resolutions on a wide variety of national issues affecting physicians in the United States.

HIV testing for health care workers and the development of a national policy regarding the new Medicare payment system were two difficult issues that received the most attention from the delegates and the national press.

With over 300 items of business and scores of ancillary caucuses, seminars, and conferences, this was a hard-working meeting that required much study and preparation for all in attendance.

New Medicare Physician Payment System

Background

By now, physicians should have received their "Dear Doctor" letter from their Medicare carriers. With these letters, or under separate cover, they should also have received a list of their 1992 Medicare payments and limiting charges for the services that they typically provide. This is the same information that the carriers must furnish every year.

Some of these 1992 payment levels have caused great concern for the physicians who have received them. Not simply because they represent a reduction in payments but because some of these declines

appear far in excess of what these physicians had been led to expect given that payment cuts for 1992 are to be limited to 15% of the full payment schedule amount. In other cases, anticipated payment increases did not occur.

Because the Final Rule on the New Medicare Physician Payment System was issued in November and the carriers began sending the "Dear Doctor" letters on November 25, there was a great need for information on how this new payment system would affect America's physicians. The AMA scheduled an open forum on Sunday, December 8, provided video tapes, and issued several "White Papers" on the subject. After lengthy debate in the Reference Committee and on the floor of the House, the delegates adopted the following policy statements to guide the Association in the coming months:

1. That the American Medical Association take the position that the RBRVS-based Medicare physician payment schedule requires substantial improvements in many of its key elements and that the American Medical Association cannot endorse this new system until substantial improvements are made.

2. That the AMA publicize and seek to extend HCFA's grace period on the new visit codes an additional two months until April 1, that it continue its comprehensive program to educate physicians on the proper

use of these codes, and that it work to ensure that HCFA engages in only educationally oriented profiling and review of the usage of these new codes until at least July 1, 1992.

3. That the AMA undertake an immediate analysis of the implementation of the new Medicare payment schedule, with a focus on whether carrier implementation is consistent with Medicare law and HCFA regulations, especially with regard to calculation and application of the Adjusted Historical Payment Basis, and that the AMA take whatever steps are needed to correct and alleviate errors in the final schedule.

4. That the AMA reaffirm and continue efforts in support of its policy to prevent any further reduction of the current Medicare limiting charges (ie, balance billing limits of 140% for evaluation and management services and 125% for all other services).

5. That the AMA seek a second Medicare participation decision period between June 1 and July 1, 1992 to allow physicians to reconsider the decision that they were forced to make in December 1991 on the basis of often limited information.

6. That the AMA expand its efforts to seek replacement of the current flawed proxy data basis for Medicare's geographic practice cost indexes (GPCIs) with current data that reflect actual practice overhead costs, that the AMA work to ensure that the professional liability component of both the GPCIs and the RBRVS more accurately reflects the actual cost experience of the physicians providing services to Medicare beneficiaries, including specialty-level

AMA House of Delegates Interim Meeting

differences in these costs.

7. That the AMA assign a continued high priority to legislative correction of grossly inequitable elements of Medicare physician payment policy as the lack of any payment for interpretation of EKGs, discriminatory payment reductions for "new" physicians, unfounded payment limits for the services of assistants-in-surgery, definition of "new" patients and the discriminatory 50 percent copayment for mental illnesses.

8. That the AMA establish a comprehensive program to monitor changes in patient access, physician practice patterns, and errors in carrier implementation under the new Medicare physician payment schedule, working closely with state and county medical societies, and that the AMA work with the Health Care Financing Administration to correct all identified deficiencies in this program.

9. That the AMA seek to achieve adequate funding for Medicare Carriers as they implement the RBRVS.

10. That the AMA work with HCFA and the national medical specialty societies to clarify HCFA's new global payment policy and to disseminate accurate information to physicians on these policies.

11. That the AMA Board of Trustees study and report to the House on the status and background of the "behavioral offset" and the "baseline adjustment" with an emphasis on the history of the use of these adjustments in Medicare Part B, including application to the RBRVS conversion factor and the MVPS.

12. That the AMA intensify its Payment Reform Education Project to provide all possible assistance to physicians as they adjust to and cope with the new Medicare payment schedule and that it evaluate the initial implementation of the new payment system, soliciting input from the entire Federation, and

commenting, as appropriate, to HCFA as part of the 120-day comment period on the relative values for the new system and as otherwise appropriate.

In related actions the House stated that the sole purpose of medical licensure is to assure the competence of physicians to practice medicine and voted to:

- oppose any attempt to tie medical licensure to a physician's obligation to take part in any payment system or plan, including Medicare.

... all patients who know they are HIV positive should be asked to notify their physician of their HIV-positive status.

HIV and Physicians

At the direction of the House of Delegates, the Board submitted a comprehensive report that reviewed the many complex issues surrounding the testing of health care workers for HIV infection, including:

- possible practice restrictions for HIV-infected health care workers
- the role of a local review committee to monitor and advise the HIV-infected health care worker
- identification of exposure prone procedures
- the need for infection control procedures
- the commitment to patient safety
- the rights of health care workers, including the right to confidentiality of his/her medical condition
- the appropriateness of mandatory physician testing
- the frequency of HIV testing for physicians
- the relationship of testing to licensing, staff privileges,

credentialling, and liability insurance.

After long and thoughtful debate the House referred some suggested modifications to the Board of Trustees for its consideration and adopted the following recommendations contained in this report:

Infection Control Procedures

Recommendation 1: All health care workers including physicians should observe universal precautions and proper infection control guidelines. Hospitals should establish procedures to see that these precautions are strictly enforced and that educational programs covering proper infection control procedures are available for all health care workers.

HIV-Infected Physician

Recommendation 2: Any physician who performs exposure-prone procedures should voluntarily determine his/her serostatus on a frequency appropriate for the risk. The periodicity will vary according to locale and circumstances of the individual and the judgment should be made at the local level. A physician who tests negative for HIV should voluntarily determine his/her HIV serostatus at an appropriate period of time after any significant occupational or personal exposure to HIV. Follow-up tests should occur after a time interval exceeding the length of the "antibody window."

Recommendation 3: A physician who performs exposure-prone procedures and becomes HIV positive should disclose his/her HIV-infected status to a local review panel as defined in previous AMA policy (Appendix V). The local review panel should establish practice limitations, if any, for all HIV infected physicians. The panel might consider the following when determining what the practice of an HIV+ physician will be;

- Morbidity and mortality experience of the physician in question.
- Frequency with which the physician performs the following:
 - Procedures that have been associated with injuries to physicians in the course of surgery;
 - Procedures that are conducted in confined or difficult to visualize anatomical spaces; and
 - Procedures where a physician's blood is likely to come in contact with a patient's mucosal surfaces, open surgical wounds or blood stream.
 - Procedures that have been known to be involved in HBV transmission; the AMA recommends that for those groups who feel the need to implement specific restrictions, they may wish to consider using the HBV model as a surrogate. However, it should be recognized that HBV is 100 times more transmissible than HIV.

Recommendation 4: The local panel should be empowered to monitor the HIV infected physician for compliance with any practice limitations established by the committee, advise the physician on the need to inform patients of his or her HIV status, monitor the infected physician's compliance with universal precautions, and assess the effects of the disease on physician competence as AIDS progresses. Physicians and others who participate in making these decisions must be protected from legal challenges and personal legal responsibility.

Recommendation 5: The AMA recommends that any HIV infected physicians who repeatedly violate local committee imposed practice limitations and/or universal precautions, be reported to state licensing boards for possible discipline.

... the Board submitted a comprehensive report that reviewed the many complex issues surrounding the testing of health care workers for HIV infection ...

Recommendation 6: An HIV-infected physician should refrain from doing exposure-prone procedures or perform such procedures with permission from the local review panel and the informed consent of the patient.

Recommendation 7: AMA reaffirm its previous policy and remain opposed to mandatory testing.

Recommendation 8: AMA reaffirm its opposition to mandatory reporting of HIV and HBV infected physicians to state licensing Boards until there is conclusive evidence that such infected physicians pose a significant or measurable risk to patients.

Recommendation 9: The AMA recommends that educational programs covering practical and didactics aspects of universal precautions and infectious control procedures be conducted for all health care workers and especially for physicians who practice invasive procedures.

Recommendation 10: The AMA reaffirm its policy that all HIV positive people, including physicians and other health care workers, be confidentially reported to the State Boards of Health.

Recommendation 11: AMA remain opposed to HIV testing as a condition of hospital medical staff privileges.

Recommendation 12: AMA should open dialogue with the professional

liability insurance companies to explore issues surrounding HIV infected physicians and liability coverage. These discussions should include the position that to date there are no scientific grounds to require testing of physicians for HIV serostatus.

Office Verification

Recommendation 13: The AMA explore the feasibility of developing a voluntary office visitation program to assess the policies, procedures and education programs that are in place concerning prevention of HIV/HBV transmissions. This effort would include exploring the feasibility of developing minimal guidelines for physician offices.

Confidentiality

Recommendation 14: The confidentiality of the HIV infected physician should be protected as with any HIV patient.

Education

Recommendation 15: The AMA should continue and enhance its campaign to educate patients on the extremely small risks of iatrogenic (physician induced) HIV infection. Public education should include information about the route of transmission, the effectiveness of universal precautions, and the efforts by organized medicine to ensure that patient risk remains immeasurably small. This program should include health care worker education as appropriate and methods to manage patient concern about HIV transmission in medical settings.

Research

Recommendation 16: The AMA should encourage further research to assess the risk of HIV transmission in specific surgical techniques and how

AMA House of Delegates Interim Meeting

any such risk may be decreased: the frequency of health care worker cuts and punctures, subsequent health care worker blood contact with the patient, and other possible avenues that might support infection transmission. Additionally, cooperation of the medical community and patients should be encouraged in scientifically sound look-back studies designed to further define the risk of HIV transmission from an infected doctor to a patient, determine if there is any scientific basis for the development of a list of exposure-prone procedures.

Health Care Workers' Safety

Recommendation 17: Employees of the health care system who might be at risk of contacts with infected fluids, eg, blood bank technicians, should be afforded the protections suggested by OSHA, and at a minimum, universal precautions must be utilized by all personnel working in blood banks. The AMA will analyze and evaluate the recently released OSHA "Bloodborne Standards" concerning its impact on physicians, physicians' offices and health institutions.

Patient Protection

Recommendation 18: When the scientific basis for patient protection policy decision is unclear, physician must error on side of protecting patients.

CDC

Recommendation 19: AMA continue to work with CDC in the management of the AIDS epidemic.

In other related actions concerning AIDS, the House adopted the following resolutions:

1. That the American Medical Association review the federal laws, including the Veteran's Benefits and Services Act which currently mandates prior written informed

... the RBRVS-based Medicare physician payment schedule requires substantial improvements in many of its key elements ...

consent for HIV testing within the Veterans Administration Hospital system, and subsequently initiate and support amendments allowing for HIV testing without prior consent in the event that a health care provider is involved in accidental puncture injury or mucosal contact by fluids potentially infected with the HIV virus in federally operated health care facilities.

2. That the American Medical Association support adequate funding and implementation of public health measures to help stop the spread of HIV/AIDS;

3. That all patients who know they are HIV positive should be asked to notify their physician of their HIV-positive status.

4. That the American Medical Association adopt the policy that physicians should be allowed, without explicit informed consent, and as indicated by their medical judgment, to perform diagnostic testing for determination of HIV status of patients suspected of having HIV infection;

5. That the AMA adopted the policy that general consent for treatment of patients in the hospital be accepted as adequate consent for the performance of HIV testing;

6. That the AMA develop model state and federal legislation, and work with the Centers for Disease Control (CDC) to permit physicians, without explicit informed consent, and as indicated by their medical judgment, to perform diagnostic testing for determination of HIV status of patients suspected of having HIV infection;

7. That the AMA reaffirm its policy that the denial of care within the expertise of the individual physician on the basis of a patient's HIV status is a violation of medical ethics (Council on Ethical and Judicial Affairs Report A, 1-87).

8. That the AMA study the problems for health care workers which stem from apparent conflicts in laws between informed consent on one side and privacy, confidentiality, and employment discrimination on the other.

There was too much business transacted to cover in this short report. However, to give you a sampling of the important issues that were addressed, here are a few actions adopted by the delegates:

1. *Conflicts of Interest: Physician Ownership of Medical Facilities* — new guidelines recommending that physicians should not refer patients to a facility in which the physician has an investment interest unless there is a demonstrated need in the community for the facility and alternative financing is not available.

2. *Health Access America* — a report containing several refinements to the AMA's proposal that has as its goal the provision of quality medical care to all Americans. The policy adopted favors addressing the cost problem with a market system rather than a centrally controlled budget-driven system.

3. *Long-Acting Contraceptives* — five policy statements opposing the involuntary use of long-acting contraceptives and opposing incentives by government to induce individuals to use a long-acting contraceptive.

4. *Insurance Company Requests for Patient Information* — a resolution that seeks to protect the patient's right to privacy as a fundamental tenet of medical care that is often disregarded by insurers.

5. *Student Loan Deferment* — a resolution calling for the AMA to redouble its efforts to prevent further

erosion of provisions regarding student loan deferment.

6. *Medicare Fee Discrimination Against New Physicians* — a resolution calling on the AMA to intensify its efforts to secure full Medicare reimbursement for payment of physicians designated by law as "new physicians."

7. *Excessive Cost of Prescription Drugs* — a resolution calling on the AMA to express its concern to the Pharmaceutical Manufacturer's Association and others as appropriate about the cost of prescription drugs.

8. *Non-Alcoholic Beer* — a resolution calling for labeling that discloses the alcohol content of so-called "non-alcoholic beer" as well as a public education campaign.

9. *Sexual Harassment: Prevention and Medical Information* — a resolution asking the AMA to urge

that the "AMA Guidelines for Establishing Sexual Harassment Prevention and Grievance Procedures" be implemented in all U.S. medical schools and residency programs by 1993.

10. *Resident working Conditions* — a report summarizing the most recent activities of the AMA toward improving resident physicians' working conditions.

11. *AMA National Campaign Against Family Violence* — a report describing the public health consequences of family violence in the U.S. and recommends a major AMA campaign on the problem including the role of substance abuse and handguns.

12. *Violence Against Women* — a report reviewing violence against women such as rape, physical and sexual assaults by marital and dating

partners, and the long-term effects of child sexual molestation against adult women.

13. *National Practitioner Data Bank* — a resolution that calls for an analysis and report on the activities of the NPDB was adopted and then amended to ask the AMA to seek to abolish the National Practitioner Data Bank.

14. *Enforcement of Code of Ethics* — a report describing an extensive program of education and enforcement of ethical guidelines and recommends a process to implement the program in coordination with the Federation, including specialty societies and hospital medical staffs.

Submitted by
Donald C. Barton, MD
KMA Senior Delegate

THE UNITED STATES ARMY RESERVE HEALTH CARE PROFESSIONALS BONUS TEST PROGRAM

\$10,000 - \$20,000 - \$30,000

The **1989 National Defense Authorization Act** required that the Department of Defense conduct a test to determine the effectiveness of a recruitment bonus to attract health care professionals to the Selective Reserve of the Army. The 1991 National Defense Authorization Act directed that the test continue.

The Bonus Test Program is offered to physicians in the following specialties:

**ANESTHESIOLOGY
ORTHOPAEDIC SURGERY**

and

GENERAL SURGERY

(Including selected subspecialties)

Applicants must be board certified or meet all requirements for board candidacy in one of the above specialties.

BONUS ELIGIBILITY: In addition to meeting all criteria for appointment as a medical corps officer in the US Army Reserve, Bonus Test applicants must be civilians and if prior service, discharged before 28 April 1989.

BONUS AMOUNTS: The test offers \$10,000 bonus for each year of affiliation with the Selected Reserve of the Army, up to a maximum of 3 years. Physicians must choose 1, 2, or 3 years of affiliation at time of application. Bonuses will be paid annually at the beginning of each year of agreed affiliation.

TEST PARAMETERS: The design of the test stipulates that bonuses be offered in certain geographic areas. To qualify, applicants must reside within those areas at the time of accession.

**TO FULLY DETERMINE YOUR ELIGIBILITY FOR THIS PROGRAM
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OR CALL COLLECT: (502) 423-7342 or 7444**

Healthy Schools, Healthy America

“In Kentucky, the KMA House of Delegates has recently voiced support of mandatory testing for Physical Education & Health.”

As the cost of medical care has escalated to near unmanageable levels, and as average life expectancy has increased, too often at the expense of quality of life, the medical profession and society at-large have been forced to adopt a new vision and definition of health. The Pew Professions Commissions National Advisory Panel of Medicine in 1991 issued *Healthy America: Practitioners for 2005*, and stated therein that medicine “enhance its vision of professional accountability to include not only the restoration of health and the relief of suffering, but also the preservation and enhancement of the health professionals.” In no arena will this linkage be more vital and more fruitful than in school-based health education and promotion.

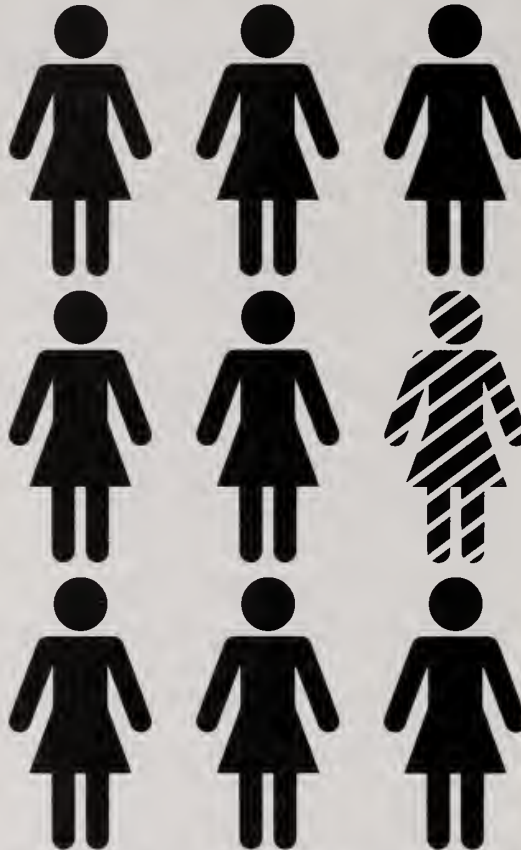
Currently, the physical fitness, health attitudes, and cognitive health skills of our school children are being questioned. A majority of our children do not participate in regular exercise and, in formal testing, cannot achieve minimal standards of aerobic and muscular fitness. Health risk inventories reveal that far too many children have smoked tobacco, with many reporting regular use. Alcohol experimentation remains frequent in both adolescents and even pre-adolescents. Perhaps most worrisome is the collective lack of cognitive understanding of health risks among school-age children. When the

realization that most behaviors pertaining to exercise, diet, and tobacco use develop during the school years is combined with the prospect of an ever-increasing population living an ever-lengthening life expectancy encumbered by diseases attendant to these behaviors, the gravity of these issues become easily apparent.

These issues require a comprehensive coordinated endeavor involving physicians, health educators, parents, and school officials designed to optimize the physical fitness, health attitudes, and cognitive health skills of our school children. Where such endeavors have been undertaken (as in Michigan and at Harvard) results have been promising. In Kentucky, the KMA House of Delegates has recently voiced support of mandatory testing for Physical Education & Health. The Jefferson County Public Schools have just announced a cooperative project with the Jefferson County Medical Society, Jefferson County Health Department, Blue Cross/Blue Shield of Kentucky Foundation, and Alliant Health System to develop a *Health Promotion Schools of Excellence Program*. These initial efforts will require expansion, modification, and revision in order to accomplish the ultimate goal of healthy schools and a healthy America.

Daniel W. Varga MD

If you think your chance
of getting breast cancer is
one in a million, the fact is,



it's one in nine.

Over their lifetimes, one out of every nine women will be faced with breast cancer. That's one out of nine friends. One out of nine sisters, mothers, daughters. It's a statistic you can't afford to ignore. And mammography is a weapon you can't afford to be without. A mammogram can detect breast cancer in its earliest stages, when it's most curable. It's not enough to simply know the statistics. You have to fight back. Get a mammogram.

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AKMA *Connections*

Our AKMA Connections have been emphasized this year through Auxiliary involvement with and support of the Kentucky Medical Association and the American Medical Association Auxiliary. Another opportunity to show our connection to the medical profession is the observance of National Doctors' Day on March 30th.

In 1933, Eudora B. Almond suggested that her auxiliary, Barrow County, Georgia Auxiliary, set aside a day to honor physicians and their work. March 30 was selected as the first Doctors' Day since it was the anniversary of the day that the famous Georgian, Dr Crawford W. Long, first used ether anesthesia in surgery — March 30, 1842.

In the spring of 1991, President George Bush proclaimed March 30 as National Doctors' Day. In his proclamation, President Bush stated that, "More than the application of science and technology, medicine is a special calling, and those who have chosen this vocation in order to serve their fellowman understand the tremendous responsibility it entails. Referring to the work of physicians, Dr Elmer Hess, a former President of the American Medical Association,

once wrote: 'There is no greater reward in our profession than the knowledge that God has entrusted us with the physical care of His people. The Almighty has reserved for Himself the power to create life, but He has assigned to a few of us the responsibility of keeping in good repair the bodies in which this life is sustained.' "

Throughout the nation, auxiliaries, hospitals, and individuals will honor their physician communities on March 30. Community service projects will be implemented in honor of Doctors' Day; health fairs will be sponsored; donations will be made to hospitals and nursing homes; and individual donations will be made to AMA-ERF in honor of physician service.

The Auxiliary to the Kentucky Medical Association would like to express appreciation to the physicians of this Commonwealth for their tireless dedication to the service of their profession. Thank you for all you do to ensure the health and safety of all members of our society.

Sam Blackstone

AKMA President

Physician Recognition Award Requirements

As of January 1, 1991, new requirements were established for the Physician Recognition Award certificates through continuing medical education criteria. The new requirements place more of an emphasis on Category 2 learning activities.

Physicians can apply for one-, two-, or three-year PRA certificates. Since many physicians have not kept formal records of Category 2 requirements, they will be phased in over a three-year period beginning in 1993. The following requirements apply:

- **3-year certificate** = 150 hours of continuing medical education
Minimum of 60 hours AMA PRA Category 1 education
Minimum of 60 hours of Category 2 education
Remaining 30 hours in either Category 1 or Category 2
- **2-year certificate** = 100 hours of CME
Minimum of 40 hours of AMA PRA Category 1 education
Minimum of 40 hours of Category 2 education
Remaining 20 hours in either Category 1 or 2
- **1-year certificate** = 50 hours of CME
Minimum of 20 hours of AMA PRA Category 1 education
Minimum of 20 hours of Category 2 education
Remaining 10 hours in either Category 1 or 2

Activities that meet the definition of CME, but are not Category 1 designation include:

- **Nonsupervised personal learning activities — self-instruction**
 - Use of database and other computer-based materials
 - Consultation
 - Patient Review Care
 - Self-assessment
- **Medical Teaching**
- **Articles, Publications, Books, and Exhibits**
- **CME lectures and seminars designated as AMA PRA Category 2 by an accredited sponsor**
- **Lectures and seminars not designated for CME credit, found by the physician-learner to be effective learning experiences**

For an information booklet on the Physician Recognition Award, contact the Division of Continuing Medical Education, American Medical Association, 515 N State Street, Chicago, IL 60610. (312) 464-4672.

APRIL

10-12 — Sports Medicine for Physicians; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

24-25 — Contemporary Pediatrics for the Practicing Physician; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

MAY

1-2 — Annual Meeting, The Virginia Society of Otolaryngology-HNS; Boar's Head Inn, Charlottesville, VA. Contact: Donna Scott, 4205 Dover Rd, Richmond, VA 23221; 804/353-2721.

8-9 — Diabetes, Lipids and Obesity: Critical Assessment of Risk Factors; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

16 — Management of Retinal Vascular and Macular Disorders; Radisson Plaza Hotel, Lexington, KY. Course Directors: William Wood, MD, and Rich Isernhagen, MD. Contact: Kay Montgomery, The Center for Advanced Eye Surgery at Humana Hospital-Lexington at 606/268-3754.

17-22 — 23rd Family Medicine Review, Session II; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

JUNE

1-3 — 60th Assembly of the Southeastern Surgical Congress, Westin Peachtree Plaza Hotel, Atlanta, GA. Contact: Roger Sherman, MD, 69 Butler St Southeast, #314, Atlanta, GA 30303; 404/221-0570.

11-13 — 37th Great Smoky Mountains Pediatric Seminar; Park Vista Hotel, Gatlinburg, TN. Contact: Continuing Medical Education, 1924 Alcoa Highway, D-116, Knoxville, TN 37920; 615/544-9190.

AUGUST

8-14 — 11th Annual Scientific Meeting and Exhibition of the Society of Magnetic Resonance in Medicine; Berlin, Germany. Contact: SMRM, 1918 University Avenue, Suite 3C, Berkeley, CA 94704; 510/841-1899; FAX 510/841-2340.

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medical
economics
A MONTHLY JOURNAL

Successfully defending a brain-damaged baby case is the courtroom equivalent of pitching a no-hitter. Because the "sympathy factor" can add millions to a jury's award, many insurance carriers would rather settle than fight.

Not so the P-I-E Mutual Insurance Co. of Cleveland, Ohio, and the 4-year-old law firm—Jacobson, Maynard, Tuschman & Kalur—that does all its defense work. In 21 brain-damaged baby cases it has defended for the 100-year-old company, its record is a remarkable 19-1: the last a hung jury. In 1988 its overall record at trial was 33 wins, 3 losses—all malpractice cases.

There's more to those numbers than luck. "Or even legal skill," adds JMT&K founding partner Aaron Jacobson, who was one of Ohio's leading plaintiffs lawyers before he, Larry E. Rogers, Herbert S. Bell, M.D., and 70 other Cleveland doctors formed P-I-E in 1975.

"It's the concept behind the firm that makes it work. These can specialty panels review every lawsuit to decide whether the defendant deviated significantly from the standard of care. If he did, we pay. If he didn't, we defend. Makes no difference whether it's a \$5,000 or a \$5 million case. We label it 'No pay.' That policy has resulted in a lot of cases being dropped. Perhaps more important, it's

DON'T YOU WISH THESE DEFENSE LAWYERS WERE YOURS?

This big, multistate firm rarely loses a case. But it's more than luck, or even legal skill, that's behind its enviable record.

By Howard Eisenberg

discouraged the filing of many other cases. Plaintiffs attorneys have learned that we're fair negotiators when our doctor's in the wrong, but won't back down when he's right."

That approach pays off. "According to the most recent report I've seen from the General Accounting Office," says Larry Rogers, P-I-E president and CEO, "in 1984, about 37 percent of medical malpractice claims were closed without payment. Through 1988, we've closed an average of 75 percent of our cases without a time-consuming trial. And it's my understanding that, without including litigation costs, St. Paul Fire and Marine Insurance Co.'s 1988 average gross payout for cases closed in Ohio with payment figure was about \$10,000 below

theirs. That's partly why we can sell an OHIO specialist in Ohio—an industrial state that ranks among the most litigious—\$1.2 million in coverage for just \$26,300."

The unique marriage of P-I-E and JMT&K has been so successful that the carrier has expanded into five other states: Indiana, Kentucky, Maryland, Missouri, and West Virginia. Where P-I-E goes, there goes JMT&K, with nine branch offices to date. The firm has 65 trial attorneys, and may well be the nation's largest devoted well-though exclusively to medical-malpractice defense.

Could the insurer-defender symbiosis, if duplicated by other doctor companies, make a significant contribution to reducing malpractice litigation nationwide? An up-close look at

how JMT&K operates may help to answer that question.

Every lawyer develops a medical specialty

"Our firm's lawyers read more medical books than law books," says P-I-E Vice President Gerard C. Oppenorth, himself a veteran defense attorney. Robert Maynard explains, "New cases are discussed at our weekly staff meeting, so that every lawyer is familiar with every case. But we assign cases to our attorneys according to medical specialty. They're well-versed in their fields, so they don't have to reinvent the wheel with each case." Last year, the firm's OHIO specialist, attorney Jerome S. Kalur, who had won 16 consecutive brain-damaged baby cases, faced one of his toughest challenges when he defended a GP

who'd attempted a midforceps delivery that ended in a C-section section and a severely brain-injured baby. Recalls Kalur, "I didn't think the doctor had caused the damage, but our position was weakened by the fact that he didn't have midforceps privileges. Based on that departure from the standard of care, our doctor panel voted to settle, and, since the hospital was also involved, a combined sum of \$1.5 million was offered. Plaintiffs turned us down flat."

"I wanted to depose the doctor, who'd been involved in the mother's care during her hospitalization, but the attorney for the plaintiff baby insisted it would violate the mother's physician-patient confidentiality. That privilege would terminate automatically when her medical

The winning firm's four founders at Cleveland's 8th District Court of Appeals (from left): Jerome S. Kalur, Aaron Jacobson, James M. Tuschman, and Robert Maynard.

records were introduced at the trial end of the plaintiff's case. Meanwhile, I was in the no-win position of having to tell the jury, 'It couldn't have been the midforceps,' without offering them another reasonable beam-damage theory."

Fortunately, the plaintiffs rested their case on a Friday afternoon, giving JMT&K time for a weekend rally. "Twenty minutes later," says Kalur, "I was in the hospital pathologist's office with an order permitting me to view the mother's placental slides." Museum-stained had been charted, and Kalur had a hunch that fetal distress had begun long before the fir-

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TOP L TO R: KMA officers seated at the head table included Chairman Russell L. Travis, MD; President S. Randolph Scheen, MD; President-Elect William B. Monnig, MD; and Immediate Past President Preston P. Nunnelley, MD. **BOTTOM:** Dennis Nutter, a senior vice president with the Gallup Organization.

Highlights of KMA December Board Meeting

Convening in a regular session, the KMA Board of Trustees held a two-day meeting on December 18 and 19. Oral reports were given, including those of the President, the Secretary-Treasurer, the Senior Delegate to AMA, the Dean of the University of Kentucky College of Medicine, the Commissioner for Health Services, Vice Chairman of the KMIC Board of Directors, and a member of the Board of Medical Licensure.

The Board members heard a detailed report on the status of the Medicaid Program, with specific emphasis on Senator Benny Ray Bailey's proposal to tax providers 6% of gross revenue. The Board expressed strong opposition to this concept, and staff outlined legislative activities relating to the Senator's proposed bill. The Director of the Medicare Part B Program, James B. Holloway, Jr, MD, also updated the Board members regarding changes in

the Medicare Program, and packets of information containing details were distributed.

The Board members reviewed a slide presentation by Arthur Andersen & Co on *The Future of Healthcare: Physician and Hospital Relationships*; and discussed the results of a statewide survey on health care with a Senior Vice President of the Gallup Organization.

Representatives of Kentucky Blue Cross and Blue Shield made a presentation regarding the KMA-endorsed BCBS plan for the membership. The Board approved terms of the plan renewal, as recommended by the KMA Committee on Medical Insurance and Prepayment Plans.

Detailed reports were given concerning the activities of the Committees on National and State Legislative Activities, which included plans for the 1992 Kentucky General Assembly. Appointments were made to the KMIC Board Election Nominating Committee, and reports of the Membership Committee and the Kentucky Physicians Care Program were also accepted.

The Board took action on various matters, including submitting the name of Wally O. Montgomery, MD, Paducah, for appointment to the AMA Council on Legislation; approved action taken to implement directives of the 1991 House of Delegates; and endorsed a recommendation of the Executive Committee to submit details of the function of the KMA Committee on Claims and Utilization Review to the Department of Insurance in accordance with a recently enacted statute.

The next meeting of the Board was scheduled for April 15-16, 1992.

KMA



TOP L to R: Trustees David C. Liebschutz, MD, and John W. McClellan, Jr, MD, are seated with AMA Delegates Robert R. Goodin, MD, Harold L. Bushey, MD, and Wally O. Montgomery, MD. **CENTER:** Trustees Mark F. Pelstring, MD, Ronald E. Waldrige, MD, Charles T. Watson, MD, and Alternate Trustee Larry J. Wilson, MD. **BOTTOM:** Trustee Don R. Stephens, MD, and KMA Vice President Ardis D. Hoven, MD.

Legislative Seminar 1992



Over 100 physicians attended the KMA Legislative Seminar in Frankfort on January 22. Members of the legislative and administrative leadership participated in KMA's seminar. Please refer to the captions for their topics of discussion.



TOP L to R: Senator Michael R. Moloney (D), Chairman, Appropriations and Revenue Committee, "Campaign and Election Reform"; Senator John A. "Eck" Rose (D), Senate President Pro-Tem, "The 1992 General Assembly Senate Perspective." **CENTER:** Representative Anne M. Northup (R), "Health and Safety Issues in 1992"; Leonard Heller, PhD, Secretary, Cabinet for Human Resources. **BOTTOM:** Senator Benny R. Bailey (D), Chairman, Health and Welfare Committee, "Omnibus Health Care Act of 1992"; Representative Susan B. Stokes (R), "A Front Burner Issue."



LEFT, top to bottom: Representative Thomas J. Burch (D), Chairman, Health and Welfare Committee, "1992 Health Agenda"; Senator Henry G. Lackey (D), "Communicating Your Issues — The Key to Legislative Success"; Pam Blackstone, AKMA President. CENTER: Wally O. Montgomery, MD, Chairman, Committee on State Legislative Activities, "The KMA Legislative Agenda"; S. Randolph Scheen, MD, KMA President; Russell L. Travis, MD, Chairman, KMA Board of Trustees; Samuel J. King, MD, Chairman, KEMPAC Board of Directors. ABOVE: Senator Nicholas Z. Kafoglis, MD (D), "Financial State of the Commonwealth."



John R. Kelly Joins KMA Staff

John R. (Jack) Kelly of Louisville joined the KMA Executive Staff on December 16, 1991.

A native of Louisville, Kelly is a graduate of Trinity High School and received his undergraduate degree from Centre College, Danville.

Jack Kelly was previously Manager of Environmental Research for the Kentucky Chamber of Commerce and has worked for several firms in the area of public relations and environmental research.

In addition to his administrative duties with KMA he will be working with membership and governmental matters.

Report of the Trustee of the KMA Seventh District

As your newly elected trustee, I would initially like to thank you for electing me to this position of high esteem and great responsibility. I would like to advise you that I wish to be accessible to you for whatever needs that you may have regarding the Kentucky Medical Association as it relates to our Seventh District. If you have any suggestions, recommendations, or grievances regarding medical activities in the Seventh District feel free to contact me.

I would also like to advise you that my staff and I have made a dedicated effort to try to understand the new Medicare payment reforms that have been recently dropped in

the laps of every physician in America. We do not claim to be experts on all of the details of this reform. However, if you have any questions that you need to get answered by someone practicing medicine, feel free to call my office or have your staff call my office if they need any help. My Medicare expert is Ruby Chambers and she will be glad to help you, or I personally will be glad to help. My phone number is 502/633-4622.

It is very important that all primary care physicians start using the new CPT codes as soon as possible and all physicians start using them by February 1, 1992. I would remind you that if you need assistance from

Medicare you can call them direct, or if you would like to speak to the Medical Director of Medicare, Dr. Holloway, his phone number is 606/281-5837. I would like to remind you that the new HCFA form has been delayed until April 1, 1992. Also, electronic billing is the way to go. If you have questions regarding the use of computers and electronic billing, feel free to contact my office for assistance.

Again, I thank you for your continued support, and I remind you that I am here to serve during my 4-year term.

Ronald E. Walldridge, MD

Rural Kentucky Medical Scholarship Fund, Inc Establish Practice Grant Program

The Establish Practice Grant Program has met with great success. The program was initiated by the Rural Kentucky Medical Scholarship Fund Inc for the purpose of meeting the current medical needs of the people in critical counties. There are 33 counties classified as critical.

Upon completion of each year of practice, the physicians who participate receive \$10,000 toward their educational debt for a maximum

of four years for a total of \$40,000 per physician.

Presently, Jerry Jamison, MD, is practicing in Russell County. Gary Partin, MD, is practicing in Adair County, Matthew Stiles, MD, is practicing in Menifee County and Stephen Toadvine, MD, is practicing in Knox County.

The RKMSF Board of Directors originally planned to offer only two grants a year, however, the program has been expanded to offer more

than two grants annually, depending upon the availability of funds.

If anyone is interested in this worthwhile program, please contact the RKMSF Office, 301 N Hurstbourne Parkway, Suite 200, Louisville, KY 40222; Telephone: 502-426-6200.

The annual meeting of the Board of Directors of the Rural Kentucky Medical Scholarship Fund, Inc is scheduled in May, 1992. *KMA*

RURAL KENTUCKY MEDICAL SCHOLARSHIP FUND

The Rural Kentucky Medical Scholarship Fund is accepting applications from residents of Kentucky, who have been accepted at the University of Kentucky College of Medicine or the University of Louisville Medical School. The Fund offers a \$10,000 loan for each year of medical school to a qualified recipient who is willing to practice and reside in a rural county in Kentucky for one year for each loan received. The interest rate is determined on May 1. Repayment options include low interest rates for recipients practicing in rural areas and loan forgiveness for those practicing in areas of the state with critical needs. The Fund is the oldest and most successful of its kind in the nation. The Rural Kentucky Medical Scholarship Fund has loaned approximately \$3 million to over 500 medical students. The deadline date for filing an application is **April 1**. Those interested in applying for a scholarship loan should contact the RKMSF Office at the Kentucky Medical Association Headquarters, 301 N Hurstbourne Pky, Ste 200, Louisville, KY 40222 or call 502/426-6200.

PEOPLE

Chapter Presidents of the KMA Medical Student Section received awards from the AMA for efforts in recruitment of medical students for AMA membership.

AMA Outreach Awards were presented to **Matt Shotwell**, a sophomore at the University of Kentucky College of Medicine, and **Daniel Wilds**, University of Louisville School of Medicine sophomore, at the AMA-MSS Interim Meeting held recently in Las Vegas. The monetary awards are given to the MSS chapters to be used in funding student leaders to attend AMA-MSS Annual and Interim Meetings.

Billy F. Andrews, MD, Louisville, is a recipient of the Wisdom Award of Honor for his achievements. He joins an exclusive list that includes Albert Einstein, Dwight Eisenhower, and Ernest Hemingway.

Wisdom is a non-profit educational society established 35 years ago for the advancement of knowledge, learning, and research in education.

Dr Andrews has been Chairman of U of L's Department of Pediatrics for nearly 25 years. He may be best known in that field for the invention of the "Billy Box," the first oxygen hood for premature babies.

As a physician, Dr Andrews has collected many honors internationally for his untiring dedication to the health and education of children everywhere.

He is responsible for the "open warmer," a device that keeps babies warm during medical procedures, and also is considered a pioneer in the field of nutrition for special needs infants.

KMA Vice President **Ardis D. Hoven, MD**, Lexington, was appointed by the AMA Board of Trustees to a ten-member Advisory Committee on

Group Practice Physicians for a 2-year term beginning January 1992.

Dr Hoven received the KMA Educational Achievement Award at the 1991 Annual Meeting. She is also Chair of the KMA Community and Rural Health Committee.

Baby Jose, MD, radiation oncologist at the U of L School of Medicine, presented "Irradiation in the Management of Anal Cancer" at a Chicago meeting in early December of the Radiological Society of North America.

UPDATES

Promising Results for UK Ovarian Screening Test

Doctors at the University of Kentucky Medical Center are studying the effectiveness of a new screening technique for ovarian cancer for women in high risk groups — those 30 and older with a family history of ovarian cancer and women over 50. The test, known as transvaginal sonography (TVS), is utilized for ovarian cancer screening only at UK and King's College in London, England.

John R. van Nagell, Jr, MD, a gynecological oncologist and director of UK's Ovarian Cancer Screening Program, said previous studies conducted at UK indicate that 90% of women who develop ovarian cancer could be cured if the cancer is detected early.

Statistics show that more than 21,000 women develop ovarian cancer annually; of that number, 12,000 die.

With the use of mammograms and PAP smears as routine screening devices, doctors have been able to reduce the number of deaths from breast and cervical cancers. Dr van Nagell hopes to prove that TVS could

have the same results for women at risk for ovarian cancer. The procedure is painless, radiation-free and can be completed in five to 10 minutes. During the examination, a small probe is placed in the vagina to take pictures and define the volume of both ovaries.

"This method has been shown to be safe, to be well-accepted by patients, and to have greater accuracy than clinical examinations or abdominal ultrasound," said Dr van Nagell.

More than 8,000 women to date have been screened by TVS in Kentucky and England. Ten were diagnosed as having primary ovarian cancer and all had Stage I disease. All these patients were found to be cancer-free following surgery and a short course of chemotherapy and all are alive and well today.

Since 1987, UK has aggressively pursued efforts to find an accurate screening tool for the early detection of this disease. In a four-year study of 1,300 postmenopausal women, 27 (2.1%) were found to have ovarian tumors on TVS.

Only 30% of these tumors could be felt during a pelvic examination. While the majority of tumors were benign, two were malignant. The two patients with cancer had normal pelvic examinations, and a blood test used to diagnose ovarian cancer — serum CA-125 — was also normal.

Women screened through UK's program who are found to have a significant increase in ovarian volume are asked to return for a second TVS in four weeks. If the abnormality does not disappear, additional tests, including a blood test, will be conducted to confirm the likelihood of an ovarian tumor. Exploratory surgery is suggested if the abnormality persists. Patients who have a malignant tumor will have it removed and may then undergo a short course of chemotherapy.

When surgery is recommended, the patient's personal physician is

notified to help her make a decision. Among the postmenopausal women who had surgery following an abnormal screening at UK, more than 60% had either a malignant tumor or a serous cystadenoma which may have malignant potential.

Participants in the UK program may return each year for another screening at no cost as long as the study continues. To be eligible, a woman must be either age 50 and above or over 30 and able to document a strong family history of ovarian cancer. For more information about the Ovarian Cancer Screening Program call 257-1096 or toll-free 1-800-76 OVARY.

Former Louisville General Hospital Transformed Into Offices

Renovation is nearly complete on the University of Louisville School of Medicine's Irvin and Helen Abell Administration Center. Located at the corner of Floyd and Chestnut streets, the former Louisville General Hospital will house offices for the dean, faculty and student advocacy, faculty committee support, business office, student affairs, curriculum, admissions, financial aid, health careers/AHEC, house staff, clinical affairs, development, alumni, and public relations. It will be dedicated early this spring.

Satellite Allows Doctors to View Surgery in France

Students were at the U of L School of Medicine and the classroom was in France during the 10th International Workshop of Diagnostic and Operative Endoscopy. Via live satellite transmission, nearly 200 health care workers and medical students across the United States watched more than a dozen surgeries as they were performed in Paris.

The surgery involved endoscopes,

which are flexible tubes holding a camera and a light to enable surgeons to peek through incisions as small as a quarter-inch to see internal organs.

"The workshop offered our medical people a rare opportunity to learn from the best in the field," says **Gary Vitale, MD**, assistant professor of surgery. "Surgeons from France, Germany, Japan, and England have been at the forefront of these procedures which are truly the surgery of the future."

Dr Vitale coordinated the workshop in Louisville for the School of Medicine's Department of Surgery.

Physicians discussed technique while they were operating and workshop participants were able to ask questions at the same time through interactive video.

"This would not be possible in the US because of all the medical and legal constraints," Dr Vitale said.

Using a split screen, participants could see the surgical team as well as the image from the scope camera. The transmission passed through satellite stations in North Carolina and Mexico before reaching Louisville. Five international phone lines kept surgeons, participants, and video technicians in constant communication.

The workshop was funded by the Olympus Corporation, a manufacturer of endoscopic equipment.

Unique Physician Identification Number (UPIN)

This is a reminder that UPINs are required for all inpatient bills with discharge dates of January 1, 1992, or after, and all Part B bills with "from" dates of January 1, 1992, or after. For more information, call the Medicare Part B carrier.

Jewish Hospital Diabetes Education Program Awarded ADA Recognition

The prestigious American Diabetes

Association Certificate of Recognition for a quality diabetes patient education program was recently awarded to the Diabetes Education Program at Jewish Hospital. The ADA Recognition process, begun in the fall of 1986 to encourage the development of quality diabetes education programs, is based on the National Standards for Diabetes Patient Education Programs.

Programs that achieve Recognition status have a staff of knowledgeable health professionals who can provide participants with comprehensive, state-of-the-art information about diabetes management.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Boyd

John Patrick Hubert, Jr, MD — TS
2301 Lexington Ave #100,
Ashland 41105

1975, U of Minnesota

Christopher L. Huerta, MD — EM
2201 Lexington Ave, Ashland 41101
1981, Washington U, St. Louis

Daviess

George Peneff, MD — AN
1412 Frederica St, Owensboro 42301
1987, U of Illinois

Daryl V. Rampton, MD — AN
1412 Frederica St, Owensboro 42301
1987, U of Louisville

Fayette

David N. Caborn, MD — ORS
UKMC, Rm E110, Lexington 40536
1981, U of Manchester, England

Paul N. H. Walmsley, MD — AN
1800 S Limestone, Lexington 40503
1980, Cambridge U, England

Floyd

Krishnarao S. Potnis, MD — OBG
PO Box 230, Martin 41649
1962, G S Medical College, Bombay

Franklin

Anita G. Rogers, MD — EM
229 Stonehedge Dr, Frankfort 40601
1986, U of Kentucky

Fulton

Ronald W. Dillow, MD — R
2000 Holiday Lane, Fulton 42041
1968, West Virginia U

Greenup

Ben J. O'Dell, MD — IM
1150 St. Christopher Dr,
Ashland 41101
1988, Marshall U

Hopkins

Jibran E. Atwi, MD — A
Trover Clinic, Madisonville 42431
1985, American U of Beirut

Mark J. Fitzmaurice, MD — OPH
Trover Clinic, Madisonville 42431
1981, Georgetown U

John F. McGurrin, MD — S
Trover Clinic, Madisonville 42431
1982, Temple U

Joseph L. Milburn, Jr, MD — IM
Trover Clinic, Madisonville 42431
1984, U of Texas

Janice Starsnic, MD — D
Trover Clinic, Madisonville 42431
1978, Jefferson Medical College

Jaroslav P. Stulc, MD — S
1200 College Dr, Madisonville 42431
1973, U of Iowa

Harlan

William A. Ankobiah, MD — IM
94 Ballpark Rd, Harlan 40831
1978, U of Ghana

Avichai Eres, MD — C
94 Ballpark Rd, Harlan 40831
1986, Ben Gurion U, Israel

Niraj Sawhney, MD — IM
94 Ballpark Rd, Harlan 40831
1978, M L Nehru Medical Col, India

Josefina P. Tienzo, MD — IM
421 US South, Harlan 40831
1979, U of the Philippines

Jefferson

Lora M. Abell, MD — FP
UL, Dept FP, Louisville 40292
1982, U of Louisville

Raymond L. Fuller, DO — IM
1025 Sanibel Way #G,
LaGrange 40031

1972, Philadelphia Col of Osteo
Medicine

Steven D. Glassman, MD — ORS
210 E Gray #900, Louisville 40202
1985, Columbia U

Robert A. Janke, MD — FP
1850 Bluegrass Ave, Louisville 40215
1960, U of Michigan

Mohamed M. Khalifa, MD — PD
334 E Broadway, Louisville 40202
1974, Cairo U, Egypt

Harold F. Klein, DMD — DENT
1169 Eastern Pkwy, Louisville 40217
Glenn M. Lipton, MD — AN

4001 Dutchmans Ln #LLF,
Louisville 40207
1985, U of Louisville

Ronald I. Paul, MD — EM
4607 Wolf Spring, Louisville 40241
1983, U of Louisville

David R. Potts, MD — OBG
601 S Floyd #307, Louisville 40202
1967, U of Illinois

Lorraine A. Rust, MD — PD
508 Ledgeview Ct, Louisville 40206
1984, U of Louisville

Johnson

Rizalina R. Lavarro, MD — PD
745 Court St, Paintsville 41240
1967, U of the East, Philippines

McCracken

Nona M. Setler-Logan, MD — FP
2110 Broadway, Paducah 42001
1984, Meharry Medical College

David C. Waggoner, MD — P
657 Lone Oak Rd #6, Paducah 42001
1969, Vanderbilt U

Northern Kentucky

Sherif G. Awadalla, MD — OBG
717 Lakewood Dr, Taylor Mill 41015
1981, U of Cincinnati

Kevin D. Martin, MD — S
311 Howell Ave, Cincinnati 45220
1982, Vanderbilt U

Bradley G. Mullen, MD — NS
85 Kyles Lane, Fort Wright 41011

1985, U of Louisville
David J. Peter, MD — EM
5365 Leels Crossing #10,
Cincinnati 45239
1987, U of Cincinnati

Pike

Gregory V. Hazelett, DO — OTO
114 Cedar Creek Rd, Pikeville 41501
1985, West Virginia School
of Osteo Med

Kay C. Hazelett, MD — OPH
114 Cedar Creek Rd, Pikeville 41501
1981, U of Kentucky

Pulaski

Michael D. Thomas, MD — FP
500 Bourne Ave, Somerset 42501
1962, U of Louisville

Shelby

Eric J. Siegel, MD — PD
515 Hospital Dr, Shelbyville 40065
1988, Jefferson Medical College

Warren

Max C. Kinnaman, Jr, MD — P
720 Second St #300,
Bowling Green 42101

1984, U of Louisville
Sherryl B. Reed, MD — IM
2700 N Mill Ave #164,
Bowling Green 42101
1988, U of Louisville

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Baretta Casey, MD — FP
David A. Francis, MD — FP
David W. French, MD — FP
Stephen C. Karem, MD — FP
Michael W. Newkirk, MD — FP
Andrew J. Ninichuck, MD — FP
W. Deon Perkins, DO — FP

St. Elizabeth's

James D. Wilson, MD — FP

DEATHS

Merle M. Mahr, MD
Madisonville
1918-1991

Merle M. Mahr, MD, a retired surgeon, died December 22, 1991. A 1945 graduate of Cornell University School of Medicine, Dr Mahr was a life member of KMA.

Joseph T. Molony, MD
Ft. Thomas
1901-1992

Joseph T. Molony, MD, a retired obstetrician-gynecologist, died January 16, 1992. Dr Molony graduated from Cincinnati College of Medicine & Surgery in 1929 and was a life member of KMA.

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William R. Willard **1908-1991**

Dr William R. Willard, the first Dean of the University of Kentucky College of Medicine, died November 18. Numerous tributes for his invaluable contributions to the medical community were forthcoming. Two are quoted here —

"Dr Willard's outstanding leadership in health science education and health care policy was known and appreciated throughout the country. His contributions to health care in Kentucky will long be remembered, particularly by the hundreds of thousands of people whose lives have been touched by the Chandler Medical Center. He was a mentor to many leaders in the health field and his recruits can be found making an impact around the world."

Peter P. Bosomworth, MD, chancellor, UK Medical Center

"Dr Willard was one of the most progressive health care administrators. Many of his visions of the medical center and of health care in general — especially those relative to concerns such as aging and public health — would be current even today. He was a true visionary."

Emery Wilson, MD, dean, UK College of Medicine

Dr Willard's service to the UK Medical Center included his appointment in 1956 as Dean of the College of Medicine, Vice President of the Medical Center, and Special Assistant to the President.

An advocate of all health professions, Dr Willard's philosophy was a major influence in the development of the UK College of Dentistry, in Nursing education, in the creation of the UK College of Allied Health Professions, and in the incorporation into the Medical Center of the UK College of Pharmacy.

Throughout his career, Dr Willard served in leadership roles in numerous national posts and received many of the nation's, and his profession's, most distinguished appointments and honors. *KMA*

KENTUCKY MEDICAL ASSOCIATION 1992 PRACTICE MANAGEMENT WORKSHOPS

March 25-26

WORKING WITH THE NEW EVALUATION & MANAGEMENT CODES

March 25 - Kentucky Inn, Lexington

March 26 - Jefferson County Medical Society Office, Louisville

Half-day workshops - 9 am - 12 noon and 1 - 4 pm; \$85 each attendee

March 24 and 27

MORE EFFECTIVE ICD-9-CM DIAGNOSIS CODING

March 24 - Kentucky Inn, Lexington

March 27 - Jefferson County Medical Society Office, Louisville

Fee: \$175, \$155 each additional attendee - 9 am - 4 pm

April 22-23

IMPROVING YOUR PRACTICE PRODUCTIVITY AND PERFORMANCE IN THE 1990s

April 22 - Kentucky Inn, Lexington

April 23 - Radisson Hotel, Louisville

Fee: \$175, \$155 each additional attendee - 9 am - 4 pm

June 1-4

MEDICAL OFFICE MANAGEMENT INSTITUTE (MOMI)

JCMS Office, Louisville

Fee: \$165 each day - 9 am to 4 pm

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- June 2 *Improving Your Managerial Techniques*
- June 3 *Patient Flow Management*
- June 4 *Financial Management*

All workshops are being presented by Conomikes Associates, Inc. For further information or registration, contact Kentucky Medical Association at (502) 426-6200 or Jefferson County Medical Society at (502) 589-2001.

RATES AND DATA

All orders for classified advertising must be placed in writing and will be subject to approval by the Editorial Board. The right is reserved to decline or withdraw advertisements at the publisher's discretion.

Deadline: First day of month prior to month of publication.

Word count: Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

Rates to KMA members: \$10 per insertion up to 50 words, 25¢ each additional word. To non-members: \$30 per insertion up to 50 words, 25¢ each additional word.

Send advance payment with order to: The Journal of KMA, 3532 Ephraim McDowell Drive, Louisville, KY 40205.

KENTUCKY — FAMILY PRACTICE RESIDENCY FACULTY POSITIONS — HAZARD, KENTUCKY. The University of Kentucky Center for Rural Health has established an innovative 1 plus 2 family practice residency program in the Appalachian region of south eastern Kentucky. The newly developed training program is designed to prepare family practitioners for rural practice. This exciting new program is in need of faculty members who are interested in combining teaching, clinical practice (including obstetrics) and research. Candidates should be board-certified or eligible, and have a strong interest in rural family medicine. Excellent fringe benefits and competitive salaries are offered. This outstanding center is located in a scenic, mountain setting with access to numerous cultural and recreational activities. Come join us in historic Appalachia. The University of Kentucky is an affirmative action/equal opportunity employer. Applicants should send current curriculum vitae and three references to: Joseph A. Florence, MD, Director, East Kentucky Family Practice Residency Program, UK Center for Rural Health, 100 Airport Gardens Road, Suite 10, Hazard, Kentucky 41701. 606/439-3557.

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Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia, HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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If, after an adequate trial of ACCUPRIL alone, based on your medical judgment as the prescribing physician, you determine that your patient requires the addition of a diuretic, Parke-Davis will refund to the patient his/her cost for the diuretic prescription less any amount reimbursed or paid for by an HMO, insurance company, or any other plan or program. For more details, ask your Parke-Davis Representative or call 1-800-955-3077.

In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.

ACCUPRIL is available in 10, 20, and 40 mg tablets. Usual initial starting dosage is 10 mg once daily.

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Please see brief summary of prescribing information on following page.

Accupril® (Quinapril Hydrochloride Tablets)

Before prescribing, please see full prescribing information. A brief summary follows.

INDICATIONS AND USAGE

ACCUPRIL is indicated for the treatment of hypertension. It may be used alone or in combination with thiazide diuretics. In using ACCUPRIL, consideration should be given to the fact that another angiotensin-converting enzyme (ACE) inhibitor, captopril, has caused agranulocytosis, particularly in patients with renal impairment or collagen vascular disease. Available data are insufficient to show that ACCUPRIL does not have a similar risk (see WARNINGS).

CONTRAINDICATIONS

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

WARNINGS

Angioedema: Angioedema of the face, extremities, lips, tongue, glottis, and larynx has been reported in patients treated with ACE inhibitors and has been seen in 0.1% of patients receiving ACCUPRIL. Angioedema associated with laryngeal edema can be fatal. If laryngeal stridor or angioedema of the face, tongue, or glottis occurs, treatment with ACCUPRIL should be discontinued immediately, the patient treated in accordance with accepted medical care, and carefully observed until the swelling disappears. In instances where swelling is confined to the face and lips, the condition generally resolves without treatment; antihistamines may be useful in relieving symptoms.

Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, emergency therapy including, but not limited to, subcutaneous epinephrine solution 1:1000 (0.3 to 0.5 mL) should be promptly administered (see ADVERSE REACTIONS).

Hypotension: Symptomatic hypotension was rarely seen in uncomplicated hypertensive patients treated with ACCUPRIL but, as with other ACE inhibitors, it is a possible consequence of therapy in salt/volume depleted patients, such as those previously treated with diuretics or dietary salt restriction or who are on dialysis (see PRECAUTIONS, DRUG INTERACTIONS, and ADVERSE REACTIONS). In controlled studies, syncope was observed in 0.4% of patients (N=3203); this incidence was similar to that observed for captopril (1%) and enalapril (0.8%).

In patients with concomitant congestive heart failure, with or without associated renal insufficiency, ACE inhibitor therapy may cause excessive hypotension, which may be associated with oliguria or azotemia and, rarely, with acute renal failure and death. In such patients, ACCUPRIL therapy should be started at the recommended dose under close medical supervision. These patients should be followed closely for the first 2 weeks of treatment and whenever the dosage of antihypertensive medication is increased (see DOSAGE AND ADMINISTRATION).

If symptomatic hypotension occurs, the patient should be placed in the supine position and, if necessary, normal saline may be administered intravenously. A transient hypotensive response is not a contraindication to further doses; however, lower doses of ACCUPRIL or reduced concomitant diuretic therapy should be considered.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression rarely in patients with uncomplicated hypertension, but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease such as systemic lupus erythematosus or scleroderma. Agranulocytosis did occur during ACCUPRIL treatment in one patient with a history of neutropenia during previous captopril therapy. Available data from clinical trials of ACCUPRIL are insufficient to show that, in patients without prior reactions to other ACE inhibitors, ACCUPRIL does not cause agranulocytosis at similar rates. As with other ACE inhibitors, periodic monitoring of white blood cell counts in patients with collagen vascular disease and/or renal disease should be considered.

Fetal/Neonatal morbidity and mortality: ACE inhibitors, including ACCUPRIL, can cause fetal and neonatal morbidity and mortality when administered to pregnant women.

When ACE inhibitors have been used during the second and third trimesters of pregnancy, there have been reports of hypotension, renal failure, skull hypoplasia, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios has been associated with fetal limb contractures, craniofacial deformities, hypoplastic lung development, and intrauterine growth retardation.

Prematurity and patent ductus arteriosus have been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure or to the mother's underlying disease. It is not known whether exposure limited to the first trimester can adversely affect fetal outcome.

A patient who becomes pregnant while taking ACE inhibitors, or who takes ACE inhibitors when already pregnant, should be apprised of the potential hazard to her fetus. If she continues to receive ACE inhibitors during the second or third trimester of pregnancy, frequent ultrasound examinations should be performed to look for oligohydramnios. When oligohydramnios is found, ACE inhibitors should generally be discontinued.

Infants with histories of in utero exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Hemodialysis and peritoneal dialysis have little effect on the elimination of quinapril and quinaprilat.

No fetotoxic or teratogenic effects were observed in rats at quinapril doses as high as 300 mg/kg/day (180 and 30 times the maximum daily human dose when based on mg/kg and mg/m², respectively), despite maternal toxicity at 150 mg/kg/day. Tested later in gestation and during lactation, reduced offspring body weight was seen at ≈ 25 mg/kg/day, and changes in renal histology (juxtaglomerular cell hypertrophy, tubular/pelvic dilation, glomerulosclerosis) were observed both in dams and offspring treated with 150 mg/kg/day. Quinapril was not teratogenic in the rabbit; however, as noted with other ACE inhibitors, maternal toxicity and embryotoxicity were seen in some rabbits at quinapril doses as low as 0.5 mg/kg/day (one time the recommended human dose) and 1.0 mg/kg/day, respectively.

PRECAUTIONS

General

Impaired renal function: As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including ACCUPRIL, may be associated with oliguria and/or progressive azotemia and rarely acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine have been observed in some patients following ACE inhibitor therapy. These increases were almost always reversible upon discontinuation of the ACE inhibitor and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some hypertensive patients with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when ACCUPRIL has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of any diuretic and/or ACCUPRIL may be required.

Evaluation of hypertensive patients should always include assessment of renal function (see DOSAGE AND ADMINISTRATION).

Hyperkalemia and potassium-sparing diuretics: In clinical trials, hyperkalemia (serum potassium ≥ 5.8 mmol/L) occurred in approximately 2% of patients receiving ACCUPRIL. In most cases, elevated serum potassium levels were isolated values which resolved despite continued therapy. Less than 0.1% of patients discontinued therapy due to hyperkalemia. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with ACCUPRIL (see PRECAUTIONS, Drug Interactions).

Surgery/anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, ACCUPRIL will block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients

Angioedema: Angioedema, including laryngeal edema, can occur with treatment with ACE inhibitors, especially following the first dose. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to stop taking the drug until they have consulted with their physician (see WARNINGS).

Symptomatic hypotension: Patients should be cautioned that lightheadedness can occur, especially during the first few days of ACCUPRIL therapy, and that it should be reported to a physician. If actual syncope occurs, patients should be told not to take the drug until they have consulted with their physician (see WARNINGS).

All patients should be cautioned that inadequate fluid intake or excessive perspiration, diarrhea, or vomiting can lead to an excessive fall in blood pressure because of reduction in fluid volume, with the same consequences of lightheadedness and possible syncope.

Patients planning to undergo any surgery and/or anesthesia should be told to inform their physician that they are taking an ACE inhibitor.

Hyperkalemia: Patients should be told not to use potassium supplements or salt substitutes containing potassium without consulting their physician (see PRECAUTIONS).

Accupril® (Quinapril Hydrochloride Tablets)

Neutropenia: Patients should be told to report promptly any indication of infection (eg, sore throat, fever) which could be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with ACCUPRIL is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions

Concomitant diuretic therapy: As with other ACE inhibitors, patients on diuretics, especially those on recently instituted diuretic therapy, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with ACCUPRIL. The possibility of hypotensive effects with ACCUPRIL may be minimized by either discontinuing the diuretic or cautiously increasing salt intake prior to initiation of treatment with ACCUPRIL. If it is not possible to discontinue the diuretic, the starting dose of quinapril should be reduced (see DOSAGE AND ADMINISTRATION).

Agents increasing serum potassium: Quinapril can attenuate potassium loss caused by thiazide diuretics and increase serum potassium when used alone. If concomitant therapy of ACCUPRIL with potassium-sparing diuretics (eg, spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes is required, they should be used with caution along with appropriate monitoring of serum potassium (see PRECAUTIONS).

Tetracycline and other drugs that interact with magnesium: Simultaneous administration of tetracycline with ACCUPRIL reduced the absorption of tetracycline by approximately 28% to 37%, possibly due to the high magnesium content in ACCUPRIL tablets. This interaction should be considered if coprescribing ACCUPRIL and tetracycline or other drugs that interact with magnesium.

Lithium: Increased serum lithium levels and symptoms of lithium toxicity have been reported in patients receiving concomitant lithium and ACE inhibitor therapy. These drugs should be co-administered with caution, and frequent monitoring of serum lithium levels is recommended. If a diuretic is also used, it may increase the risk of lithium toxicity.

Other agents: Drug interaction studies of ACCUPRIL with other agents showed:

- Multiple dose therapy with propranolol or cimetidine has no effect on the pharmacokinetics of single doses of ACCUPRIL.
- The anticoagulant effect of a single dose of warfarin (measured by prothrombin time) was not significantly changed by quinapril coadministration twice-daily.
- ACCUPRIL treatment did not affect the pharmacokinetics of digoxin.
- No pharmacokinetic interaction was observed when single doses of ACCUPRIL and hydrochlorothiazide were administered concomitantly.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Duinapril hydrochloride was not carcinogenic in mice or rats when given in doses up to 75 or 100 mg/kg/day (50 to 60 times the maximum human daily dose, respectively, on a mg/kg basis and 3.8 to 10 times the maximum human daily dose when based on mg/m² basis) for 104 weeks. Female rats given the highest dose level had an increased incidence of mesenteric lymph node hemangiomas and skin/subcutaneous lipomas. Neither quinapril nor quinaprilat were mutagenic in the Ames bacterial assay with or without metabolic activation. Duinapril was also negative in the following genetic toxicology studies: *in vitro* mammalian cell point mutation, sister chromatid exchange in cultured mammalian cells, micronucleus test with mice, *in vitro* chromosome aberration with V79 cultured lung cells, and in an *in vivo* cytogenetic study with rat bone marrow. There were no adverse effects on fertility or reproduction in rats at doses up to 100 mg/kg/day (60 and 10 times the maximum daily human dose when based on mg/kg and mg/m², respectively).

Pregnancy

Pregnancy Category D: See WARNINGS, Fetal/Neonatal morbidity and mortality.

Nursing Mothers

It is not known if quinapril or its metabolites are secreted in human milk. Duinapril is secreted to a limited extent, however, in milk of lactating rats (5% or less of the plasma drug concentration was found in rat milk). Because many drugs are secreted in human milk, caution should be exercised when ACCUPRIL is given to a nursing mother.

Geriatric Use

Elderly patients exhibited increased area under the plasma concentration time curve (AUC) and peak levels for quinaprilat compared to values observed in younger patients; this appeared to relate to decreased renal function rather than to age itself. In controlled and uncontrolled studies of ACCUPRIL where 918 (21%) patients were 65 years and older, no overall differences in effectiveness or safety were observed between older and younger patients. However, greater sensitivity of some older individual patients cannot be ruled out.

Pediatric Use

The safety and effectiveness of ACCUPRIL in children have not been established.

ADVERSE REACTIONS

ACCUPRIL has been evaluated for safety in 4960 subjects and patients. Of these, 3203 patients, including 655 elderly patients, participated in controlled clinical trials. ACCUPRIL has been evaluated for long-term safety in over 1400 patients treated for 1 year or more.

Adverse experiences were usually mild and transient.

Discontinuation of therapy because of adverse events was required in 4.7% of patients treated with ACCUPRIL in placebo-controlled hypertension trials.

Adverse experiences probably or possibly related to therapy or of unknown relationship to therapy occurring in 1% or more of the 1563 patients in placebo-controlled hypertension trials who were treated with ACCUPRIL are shown below.

Adverse Events in Placebo-Controlled Trials

	ACCUPRIL (N = 1563) Incidence (Discontinuation)	Placebo (N = 579) Incidence (Discontinuation)
Headache	5.6 (0.7)	10.9 (0.7)
Dizziness	3.9 (0.8)	2.6 (0.2)
Fatigue	2.6 (0.3)	1.0
Coughing	2.0 (0.5)	0.0
Nausea/Vomiting	1.4 (0.3)	1.9 (0.2)
Abdominal Pain	1.0 (0.2)	0.7

Clinical adverse experiences probably or possibly related, or of uncertain relationship to therapy, occurring in 0.5% to 1.0% (except as noted) of the patients treated with ACCUPRIL (with or without concomitant diuretic) in controlled or uncontrolled trials (N = 4397) and less frequent, clinically significant events seen in clinical trials or post-marketing experience (the rarer events are in italics) include (listed by body system):

General: back pain, malaise

Cardiovascular: palpitation, vasodilation, tachycardia, heart failure, hyperkalemia, myocardial infarction, cerebrovascular accident, hypertensive crisis, angina pectoris, orthostatic hypotension, cardiac rhythm disturbances

Gastrointestinal: dry mouth or throat, constipation, gastrointestinal hemorrhage, pancreatitis, abnormal liver function tests

Nervous/Psychiatric: somnolence, vertigo, syncope, nervousness, depression

Integumentary: increased sweating, pruritus, exfoliative dermatitis, photosensitivity reaction

Urogenital: acute renal failure

Other: amblyopia, pharyngitis, sinusitis, bronchitis, agranulocytosis, thrombocytopenia

Angioedema: angioedema has been reported in patients receiving ACCUPRIL (0.1%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with ACCUPRIL should be discontinued and appropriate therapy instituted immediately. (see WARNINGS.)

Clinical Laboratory Test Findings

Hematology: (See WARNINGS)

Hyperkalemia: (See PRECAUTIONS)

Creatinine and blood urea nitrogen: Increases (>1.25 times the upper limit of normal) in serum creatinine and blood urea nitrogen were observed in 2% and 2%, respectively, of patients treated with ACCUPRIL alone. Increases are more likely to occur in patients receiving concomitant diuretic therapy than in those on ACCUPRIL alone. These increases often remit on continued therapy.

* In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.



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COVER: This illustration by Joanne Weis, Chief Operating Officer, The Center for Women & Families, graphically depicts the abuse sustained by some of the Center's clients.

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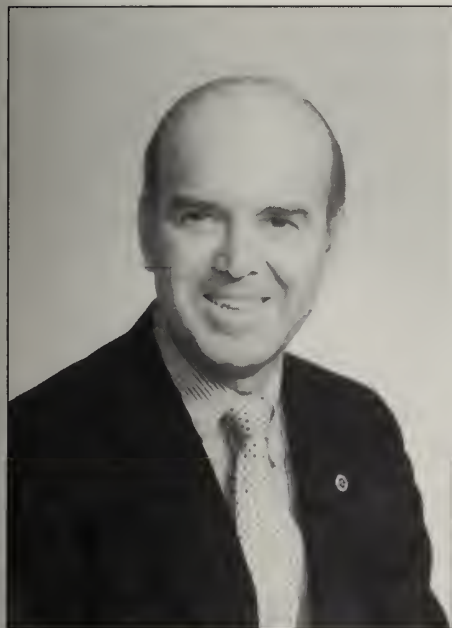
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Action in Frankfort

Well, as you know, there are a number of very important issues pertaining to physicians being considered in Frankfort at this meeting of our state legislature. We are fortunate to have dedicated members of our staff at KMA, our lobbyists, and your Legislative Committee, as well as our Quick Action Committee of the KMA, to monitor these issues. They meet on a weekly basis in Frankfort to review and follow bills which have already been introduced, as well as to discuss any new bills. They determine what effect these bills will have on our medical care delivery system and our patients in Kentucky. After an indepth discussion, a decision is made whether to support or oppose any bill. Their activities are reported to you in your *KMA Legislative Bulletin* and provide you with up-to-date information on all bills of importance to medicine in the legislature. I urge you to read this bulletin and respond when we ask for your input and support by calling or writing your state legislator.

I don't have to tell you that the problems of health care access and health care costs are in the forefront of all legislative bodies nationally as well as in individual states. Kentucky is no exception. We expect a lot of activity in this area and on these issues facing this legislature. On a positive note, the Governor will appoint a Blue Ribbon Commission on Health Care Costs and Access. This will be similar to the commission which was established for education reform and will be composed of legislators and members of the administration as was discussed in your last *Legislative Bulletin*. We will

be carefully and anxiously awaiting the appointment of the members of this Commission. We look forward to the opportunity to work with this Commission and the Governor to do our best to resolve this problem as much as possible for the benefit of physicians and the people of the Commonwealth of Kentucky.

With the appointment of this Commission, the Governor will be seeking advice from those most acutely aware of and knowledgeable concerning this problem and those with the expertise to propose solutions. That would be the medical care providers, the physicians of Kentucky. We will have an opportunity to be proactive rather than reactive. We must take an offensive and leadership role and present recommendations from our medical sector that are positive in their language and give direction to this Commission as to the paths that must be followed in order to obtain not a short-term fix, but a program with not only immediate but lasting results.

It is a time when we must all work together to accomplish our goals. It is a time when all of our Kentucky physicians must give us their input and support. Tell us how to best direct our energies toward the achievement of these goals so that, as stated in our Constitution, "The profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life."

S. Randolph Scheen, MD
President

“We will have an opportunity to be proactive rather than reactive. We must take an offensive and leadership role . . .”

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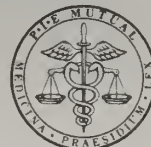
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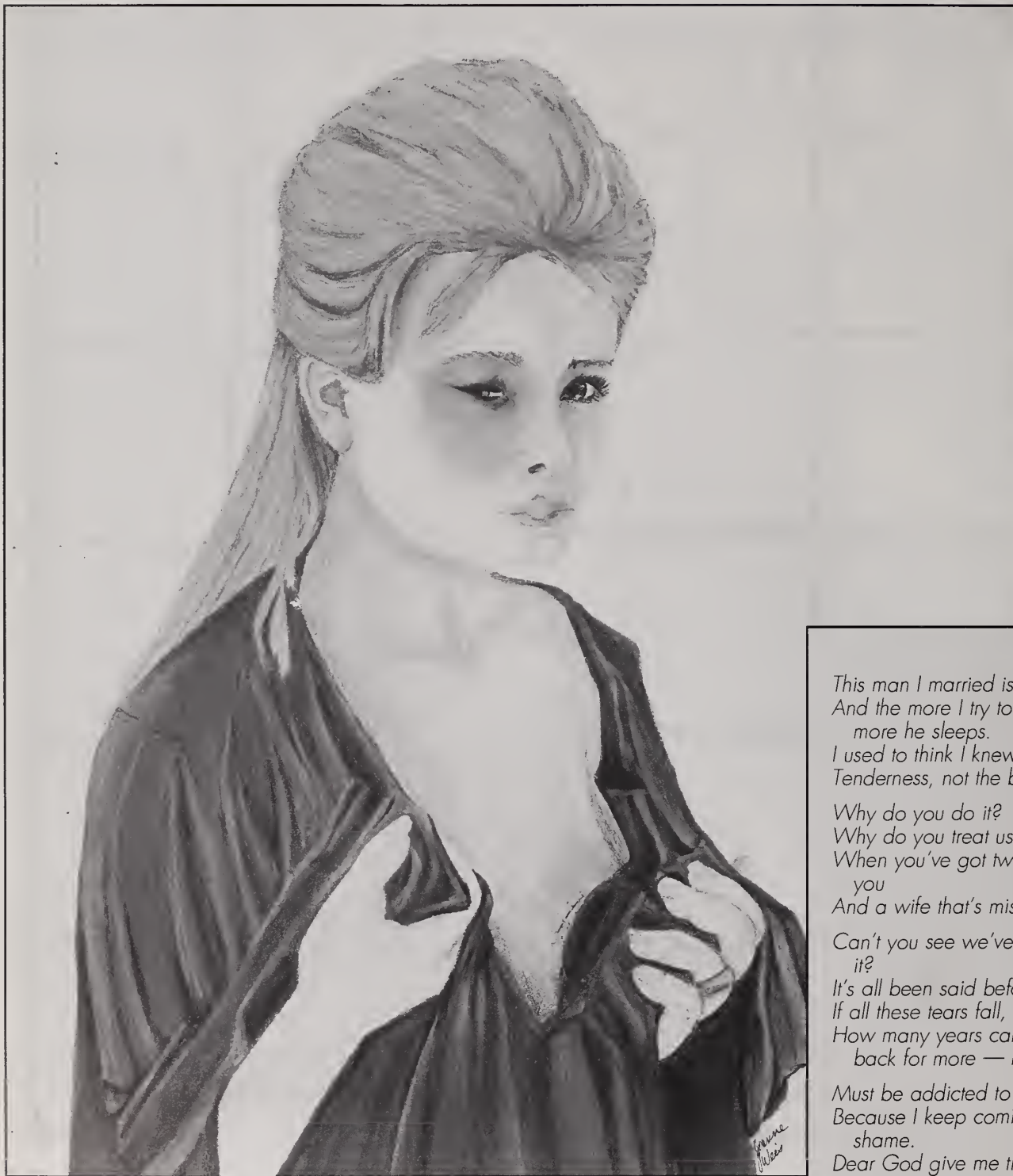
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*This man I married is very deep
And the more I try to wake him the
more he sleeps.
I used to think I knew this man
Tenderness, not the back of his hand.*

*Why do you do it?
Why do you treat us so bad?
When you've got two kids who love
you
And a wife that's missing you bad.*

*Can't you see we've both been through
it?*

*It's all been said before.
If all these tears fall,
How many years can I keep coming
back for more — no more.*

*Must be addicted to all this pain
Because I keep coming back for the
shame.*

*Dear God give me the strength to
leave,
I've got to keep going — keep going
this time.*

— TONI CHILDS
Popular Folk Singer

Domestic Violence — The Medical Community's Legal Duty

Stephen L. Henry, MD; Marcia Roth, BA; Linda H. Gleis, MD

During the last decade, domestic violence has been identified as one of the major causes of emergency room visits by women. As many as 30% of the women who are seen by emergency room physicians exhibit at least one or more symptoms of physical abuse. Unfortunately, the vast majority of these cases go unreported due to a lack of awareness on the part of physicians and other health care providers regarding the law, actual reporting procedures, and potential liability.

This article addresses both the medical community's legal liability and the results of a January 1992 survey conducted by the Jefferson County Medical Society and University of Louisville. This survey evaluated local physicians' awareness of the statutory requirements imposed on the medical community when treating suspected victims of domestic violence. According to this survey of 215 physicians, only 29% were aware that Kentucky law requires physicians and other health care practitioners to report to the Cabinet for Human Resources any suspected abuse, neglect, or exploitation of an adult. Furthermore, the Jefferson County Medical Society survey reported that only 24% of the physicians polled had ever filed a domestic violence report on behalf of a patient.

In an effort to compare the physicians' knowledge of other domestic violence issues, the physicians were also questioned regarding the issue of child abuse. Over 80% of physicians surveyed were aware of the Kentucky statute which requires a physician to report child abuse, and greater than 60% of those physicians surveyed had filed a complaint with a local or state agency.

Domestic violence is now being publicly recognized as a social problem with far-reaching consequences. Physicians and other health care providers must now assist these victims and help break the cycle of abuse by promptly reporting such incidents.

Introduction

Historically, domestic violence has often been ignored, disguised, or even perceived as acceptable behavior. Series of assaults which occurred in the home were not effectively reported until 1960. However, most of these studies concentrated on physical child abuse, as incidents of spouse abuse were rarely reported. Only a few forms of violence such as assault or rape by strangers or casual acquaintances were seen as legitimate dangers to women.

The anti-rape movement of the 1960s helped bring to the forefront a new understanding and knowledge of violence against women. Although this movement concentrated mainly on sexual violence against women by strangers or acquaintances, it was instrumental in encouraging further discussion and discovery of physical assaults of women by male intimates.

Studies now indicate that women in the United States are more likely to be assaulted and injured, raped, or killed by a current or ex-male partner than by any other type of assailant.^{1,6} Surgeon General Dr Antonio Novello has reported:

... the home is actually a more dangerous place for American women than the streets. More than a third of the women slain in this country die at the hands of husbands or boy-friends, and domestic violence is the single largest cause of injury to women in the United States. Domestic violence causes more injuries to women than automobile accidents, mugging and rapes combined ... but sadly, the medical community has yet to consistently identify these women as victims and extend treatment beyond the physical manifestations of an abusive relationship.

Surgeon General Novello, a pediatrician, further reported "Physicians have played a vital role

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in the movement to prevent and treat abused children but have barely addressed other forms of family violence, including sexual abuse of the elderly."⁷

Materials and Methods

In an effort to determine physician knowledge and response to domestic violence, a questionnaire was administered to practicing physicians, residents, and medical students through the Jefferson County Medical Society and the University of Louisville Medical School.

Two hundred and twenty-seven physicians — 134 practicing, 53 in-training, ie, residents, interns and 40 medical students were questioned in a random survey. In-training physicians were randomly selected by service and years of training. Of the 53 residents and interns questioned, 32 were surgical house staff and 21 were non-surgical. Of those practicing physicians who responded, 25% had been in practice less than 5 years, 30% had been in practice between 6 and 20 years, and 45% over 20 years. The questions were written so that responses would compare the physician's attitude and knowledge between spouse and child abuse. Each physician was

asked if spouse abuse was reportable by law and to what authority if spouse abuse was suspected. The physician was then asked if any statute required their reporting of suspected cases. Also, the physician was asked that if no statute existed, should a statute be legislated to require a health care provider to report suspected spouse abuse. In addition, each physician was asked if he or she had ever reported spouse abuse. Finally each question was asked again interchanging child abuse for spouse abuse (Table 1).

Results

Among practicing physicians, only 24% had ever filed a spouse abuse report, as compared to 63% who had previously reported child abuse ($p < .05$). Of the physicians responding, only 29% were aware of the KRS statute requiring physicians to report confirmed or suspected spouse abuse (Table 2). In contrast, over 81% of the surveyed physicians were aware of the Kentucky statute which requires reporting of child abuse. In-training physicians were slightly more knowledgeable regarding spouse abuse, as 35% of the respondents were aware of the Kentucky statute which requires reporting. Sixty-four percent of in-training physi-

Table 1. Domestic Violence Poll

Spouse Abuse	Child Abuse
1. As a medical professional, have you ever reported spouse abuse? ____ Yes ____ No	1. As a medical professional, have you ever reported child abuse? ____ Yes ____ No
2. If so, to whom did you report the confirmed or suspected spouse abuse? ____ DSS* ____ police ____ other	2. If so, to whom did you report the confirmed or suspected child abuse? ____ DSS* ____ police ____ other
3. Does any statute require you as a medical professional to report confirmed and/or suspected spouse abuse to the authorities? ____ Yes ____ No ____ Don't know	3. Does any statute require you as a medical professional to report confirmed and/or suspected child abuse to the authorities? ____ Yes ____ No ____ Don't know
4. In your practice, approximately how many times a year do you see or suspect that you have seen a patient who is a victim of spouse abuse? ____ 0-5 times ____ 5-10 times ____ more than 10 times	4. In your practice, approximately how many times a year do you see or suspect that you have seen a patient who is a victim of child abuse? ____ 0-5 times ____ 5-10 times ____ more than 10 times
5. Do you think a statute should require you as a medical professional to report spouse abuse? ____ Yes ____ No	5. Do you think a statute should require you as a medical professional to report child abuse? ____ Yes ____ No
Please indicate number of years in practice: ____ 1-5 ____ 6-10 ____ 11-15 ____ 16-20 ____ 21-25 ____ 26-30 ____ 31-35 ____ 36-40 ____ 41-45 ____ 46-50 ____ 51+	

*Dept of Social Services

cians were aware of the Kentucky statute requiring the physician to report suspected child abuse.

Physicians were next asked their opinion regarding the need for a statute requiring mandatory reporting of spouse abuse and child abuse. Only 67% of practicing physicians supported a mandatory reporting requirement for spouse abuse as compared to 82% for child abuse. In-training physicians (medical students, interns and residents) were generally more supportive of mandatory reporting for both spouse and child abuse, 77% and 95% respectively. However, approximately 15% of both physician groups (practicing and in-training) supported a reporting statute for child abuse yet opposed a similar statute for spouse abuse (Table 3).

Discussion

Today, issues such as child abuse are well recognized by the medical community due to the fact that local medical organizations have placed a priority on their education. The results of this survey highlight this fact because over 80% of surveyed physicians were aware of the Kentucky statute which requires reporting of child abuse to the Kentucky Department of Social Services. The fact that less than 30% of Kentucky physicians were aware of a similar statute requiring them to report confirmed or suspected spouse abuse dramatizes the need for a comprehensive educational effort within the medical community.

The results of the physician survey reflect the need for joint educational efforts by the state and local medical communities and agencies of the city, county, and state government. Local governmental seminars and symposiums can be valuable resources in educating nurses, nurse practitioners, physical and occupational therapists, social workers, and the clergy as to their responsibility concerning spouse abuse. However, it is the responsibility of the medical community, ie, Jefferson County Medical Society, Kentucky Medical Association, and the American Medical Association to initiate educational programs concerning domestic violence to educate the physician in an effort to eliminate this social disease.

The education process on such issues should begin in the early stages of medical training. Social issues and responsibilities of physicians have in the past been well received by the medical school curriculum. In our survey of in-training physicians, which included medical students, interns, and residents, over 60% were aware of the

Table 2.

Practicing Physicians	Spouse Abuse	Child Abuse
Physicians who have reported incidents	24%	63%
Physicians who correctly identified agency to report to (DSS)	25%	60%
Physicians who knew of existing statute	29%	81%
Physicians who believed there should be statute	67%	82%
In-Training Physicians	Spouse Abuse	Child Abuse
In-training physicians who knew of existing statute	35%	64%
In-training physicians who believed there should be statute	77%	95%

Table 3.

	Years in Practice		
	1-5 (25%)	6-20 (30%)	20+ (45%)
Spouse Abuse			
Physicians who have reported incidents	37%	36%	19%
Physicians who correctly identified agency to report to (DSS)	32%	32%	12%
Physicians who knew of existing statute	27%	28%	34%
Physicians who believed there should be statute	73%	78%	57%
Child Abuse			
Physicians who have reported incidents	64%	65%	36%
Physicians who correctly identified agency to report to (DSS)	59%	60%	29%
Physicians who knew of existing statute	81%	73%	74%
Physicians who believed there should be statute	81%	93%	70%

mandatory obligation to report child abuse. This fact speaks well for the early dissemination of information regarding the battered child syndrome. It also speaks for the effectiveness of placing social issues and physician responsibilities into the medical school curriculum.

The issue of mandatory reporting may be somewhat controversial among the medical community, but the General Assembly clearly places the duty of reporting on the shoulders of the law enforcement and medical communities. When asked if they supported a mandatory reporting requirement for spouse abuse, only 67% of practicing physicians responded affirmatively. The survey noted that well over 82% supported a similar law for child abuse.

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Several reasons seem to be apparent for this diversity of opinion. Physicians have always been loyal to the ethical and legal responsibilities of the confidential patient-physician relationship. In many cases of spouse abuse, the victim complicates the physician's position by frequently refusing multiple attempts to notify the appropriate agency, ie, the Department of Social Services. Many physicians find this dilemma difficult to resolve due to the fact that the victim denies the abuse and the injuries may not be as easily attributed to abuse as those seen in children. With only a suspicion of abuse and an unwilling patient, the physician has been hesitant to file a complaint. However, the statutory requirement of the physician is clear.

The Law

Recently the courts, police, and the media have recognized domestic violence as a chronic social problem with far-reaching consequences. Realizing the urgency of this problem, the General Assembly placed a duty on those who serve on the front line of this problem (police and health care providers) to notify the appropriate agencies in the hope that the victims of the physical and emotional abuse can be helped and the cycle of abuse can be interrupted.

In an attempt to provide some measure of assistance and protection to the victims of domestic violence the Kentucky General Assembly enacted KRS 209.030. This statute specifically requires physicians, law enforcement officers, and health care providers to notify the Cabinet for Human Resources of suspected abuse, neglect, or exploitation of an adult.

According to Kentucky Revised Statute 209.030(2):

- (2) Any person, including, but not limited to, physician, law enforcement officer, nurse, social worker, department personnel, coroner, medical examiner, alternate care facility employee, or caretaker, having reasonable cause to suspect that an adult has suffered abuse, neglect, exploitation, shall report or cause reports to be made in accordance with the provisions of this chapter. Death of the adult does not relieve one of the responsibility for reporting the circumstances surrounding the death.
- (3) An oral or written report shall be made

immediately to the department upon knowledge of the occurrence of suspected abuse, neglect, or exploitation of an adult. Any person making such a report shall provide the following information, if known: The name and address of the adult; the nature and extent of the abuse, neglect, or exploitation; the identity of the perpetrator, if known; the identity of the complainant, if possible; and any other information that the person believes might be helpful in establishing the cause of abuse, neglect, or exploitation.

KRS 209.030(2)(3) (emphasis added)

According to KRS 209.030, if a physician has a reasonable cause to suspect that a patient has been a victim of abuse, the physician is required by law to submit a written or oral report immediately to the Department for Social Services. Physicians may call the Adult/Child Abuse Reporting Hotline Kentucky Statewide Toll Number at 1-800-752-6200. The statute permits physicians and other health care providers to make reports to the Cabinet for Human Resources **anonymously** if so desired.

KRS 209.030 (3) declares that the report shall include the nature of the exploitation with or without a history of prior abuse, the identity and relationship of the perpetrator, the identity of the victim, and any additional information and facts to assist in documenting the abuse, neglect, or exploitation. The statute instructs physicians and other health care providers to provide as much relevant information as possible so that the various social service and law enforcement agencies may thoroughly investigate the suspected abuse victim and abuser.¹⁰

Upon receiving a report pursuant to KRS 209.030 the Department for Social Services will notify the appropriate law enforcement official. In addition, the Department for Social Services will conduct an investigation and recommend whether further action will ensue.

Immunity and Liability for Physicians and Health Care Providers

Reporting of suspected spouse abuse is not a breach of the physician-patient privilege. The General Assembly in KRS 209.050 specifically grants physicians and other health care providers immunity from civil or criminal liability for filing

a report of suspected abuse, neglect, or exploitation of an adult. If a physician or health care worker has reasonable cause to file a report, requests an investigation, or assists in obtaining an emergency protective service for an adult, then the physician or health care provider is granted immunity from civil or criminal liability. According to KRS 209.050:

Anyone acting upon reasonable cause in the making of any report or investigation or participating in the filing of a petition to obtain injunctive relief or emergency protective services for an adult pursuant to this chapter, including representatives of the department in the reasonable performance of their duties in good faith, and within the scope of their authority, shall have immunity from any civil or criminal liability that might otherwise be incurred or imposed. Any such participant shall have the same immunity with respect to participation in any judicial proceeding resulting from such report or investigation and such immunity shall apply to those who render protective services in good faith pursuant either to the consent of the adult or to court order.

KRS 209.050

The General Assembly has imposed harsh penalties for any physician or health care provider who fails to file a report of suspected spouse abuse. According to KRS 209.990, any physician who fails to report suspected abuse may be found guilty of a Class B misdemeanor. Therefore, by continuing to ignore the duty placed on physicians and other health care practitioners by the General Assembly, members of the medical community are in jeopardy of not only civil suits and judgments but may face a criminal fine of \$500 and up to 180 days in jail.

Anyone knowingly and willfully violating the provisions of KRS 209.030(2) shall be guilty of a Class B misdemeanor as designated in KRS 532.090.

KRS 209.990 (1)

Physicians cannot take legal refuge in the physician-patient privilege. An advisory opinion by the Kentucky Attorney General's office declares:

There is no bar by virtue of the physician-patient relationship to the report of a case of suspected adult abuse by the attending physician, and therefore, physicians who de-

cline to make the report as required by this section if the adult abuse victim is receiving medical treatment are clearly violating the express language of subsection (2) of this section which reads "... shall report."

OAG 83-187

Differences in the physician's knowledge and reporting of spouse and child abuse may be a reflection of current trends in medical education. During the last decade the issue of child abuse has been thoroughly discussed in the curriculum of national medical schools and has been emphasized on in-training and licensure exams for postgraduate certification. Unfortunately, no similar efforts have been made to successfully integrate the issue of spouse abuse into the educational curriculum of either of Kentucky's medical schools.

Although each situation may appear different, the physician should look for a specific pattern of injuries, ie, bruises, cuts, black eyes, contusions, broken bones, burns, scars, bites, or knife wounds (Fig 1). The physician should be aware



Fig 1 — AP x-ray of a 30-year-old female who sustained a fractured forearm (ulna) as a result of domestic abuse.

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Fig 2 — AP x-ray of a 34-year-old female who sustained a proximal femur fracture when her live-in boyfriend intentionally backed an automobile over her.

of the repetitions of such injuries and the clustering of episodes.⁸ Injuries relating to the battered woman syndrome are more distinguishable from accidental injuries in that they are less likely to involve the periphery of the body. In one hospital based study, victims of domestic violence were 13 times more likely to sustain an injury to the breast, chest, or abdomen, than trauma victims⁹ (Figs 2 and 3).

Physicians should be alerted as they treat women to observe certain patterns of injuries, particularly when seen with evidence of old injuries or associated with vague complaints of aches and pains. The physician should suspect abuse regardless of the explanation given for the injuries. Less frequently, victims of domestic violence may complain of less obvious symptoms such as chronic headaches, abdominal pains, muscle aches, sleeping and eating disorders, and depression. These women may resort to the abuse of alcohol and prescription drugs which further complicates the diagnosis and process of identification.



Fig 3 — AP x-ray of a healing femur fracture treated with an intramedullary nail. In this patient's case, the Department of Social Services and the local police department intervened to assist in successfully resolving the domestic problem.

Conclusion

During the last decade the issue of domestic violence has been transformed from one perceived as unimportant to one recognized as a significant cause of injuries to women in this country today. It is critical that the physician intervene as the patient's advocate by contacting the Department for Social Services.

Misdiagnosis of these victims and lack of proper intervention may allow the domestic violence to escalate to homicide, suicide, or inappropriate institutionalization. Without intervention, domestic violence evolves in not just a vicious cycle, but a downward spiral. Timely intervention

by health care professionals can create the environment for change to end this cycle of domestic abuse. The role of health care professional cannot be overestimated in preventing domestic violence from taking the ultimate human toll. Physicians are an important key to ending this crime, as are the police, prosecutors, and the judicial system. It is a duty that may not come easily to trained medical professionals, but one that they must assume.

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A = Have people **annoyed** you by criticizing your drinking?

G = Have you ever felt bad or **guilty** about your drinking?

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Considerations before you prescribe Cytotec

- Because of its abortifacient property, Cytotec should not be prescribed for women who are pregnant. Patients must be advised of the abortifacient property and warned not to give the drug to others.



BRIEF SUMMARY

CONTRAINDICATIONS AND WARNINGS: Cytotec (misoprostol) is contraindicated, because of its abortifacient property, in women who are pregnant. (See *Precautions*.) Patients must be advised of the abortifacient property and warned not to give the drug to others. Cytotec should not be used in women of childbearing potential unless the patient requires nonsteroidal anti-inflammatory drug (NSAID) therapy and is at high risk of complications from gastric ulcers associated with use of the NSAID, or is at high risk of developing gastric ulceration. In such patients, Cytotec may be prescribed if the patient

- is capable of complying with effective contraceptive measures.
- has received both oral and written warnings of the hazards of misoprostol, the risk of possible contraception failure, and the danger to other women of childbearing potential should the drug be taken by mistake.
- has had a negative serum pregnancy test within two weeks prior to beginning therapy.
- will begin Cytotec only on the second or third day of the next normal menstrual period.

INDICATIONS AND USAGE: Cytotec (misoprostol) is indicated for the prevention of NSAID (nonsteroidal anti-inflammatory drugs, including aspirin)-induced gastric ulcers in patients at high risk of complications from gastric ulcer, eg, the elderly and patients with concomitant debilitating disease, as well as patients at high risk of developing gastric ulceration, such as patients with a history of ulcer. Cytotec has not been shown to prevent duodenal ulcers in patients taking NSAIDs. Cytotec should be taken for the duration of NSAID therapy. Cytotec has been shown to prevent gastric ulcers in controlled studies of three months' duration. It had no effect, compared to placebo, on gastrointestinal pain or discomfort associated with NSAID use.

CONTRAINDICATIONS: See boxed **CONTRAINDICATIONS AND WARNINGS**.

Cytotec should not be taken by anyone with a history of allergy to prostaglandins.

WARNINGS: See boxed **CONTRAINDICATIONS AND WARNINGS**.

PRECAUTIONS:

Information for patients: Cytotec is contraindicated in women who are pregnant, and should not be used in women of childbearing potential unless the patient requires nonsteroidal anti-inflammatory drug (NSAID) therapy and is at high risk of complications from gastric ulcers associated with the use of the NSAID, or is at high risk of developing gastric ulceration. Women of childbearing potential should be told that they must not be pregnant when Cytotec therapy is initiated, and that they must use an effective contraception method while taking Cytotec.

See boxed **CONTRAINDICATIONS AND WARNINGS**.

Patients should be advised of the following:

Cytotec is intended for administration along with nonsteroidal anti-inflammatory drugs (NSAIDs), including aspirin, to decrease the chance of developing an NSAID-induced gastric ulcer.

Cytotec should be taken only according to the directions given by a physician.

If the patient has questions about or problems with Cytotec, the physician should be contacted promptly.

THE PATIENT SHOULD NOT GIVE CYTOTEC TO ANYONE ELSE. Cytotec has been prescribed for the patient's specific condition, may not be the correct treatment for another person, and may be dangerous to the other person if she were to become pregnant.

The Cytotec package the patient receives from the pharmacist will include a leaflet containing patient information. The patient should read the leaflet before taking Cytotec and each time the prescription is renewed because the leaflet may have been revised.

Keep Cytotec out of the reach of children.

SPECIAL NOTE FOR WOMEN: Cytotec must not be used by pregnant women. Cytotec may cause miscarriage. Miscarriages caused by Cytotec may be incomplete, which could lead to potentially dangerous bleeding, hospitalization, surgery, infertility, or maternal or fetal death.

Drug interactions: See *Clinical Pharmacology*. Cytotec has not been shown to interfere with the beneficial effects of aspirin on signs and symptoms of rheumatoid arthritis. Cytotec does not exert clinically significant effects on the absorption, blood levels, and antiplatelet effects of therapeutic doses of aspirin. Cytotec has no clinically significant effect on the kinetics of diclofenac or ibuprofen.

Animal toxicology: A reversible increase in the number of normal surface gastric epithelial cells occurred in the dog, rat, and mouse. No such increase has been observed in humans administered Cytotec for up to one year.

An apparent response of the female mouse to Cytotec in long-term studies at 100 to 1000 times the human dose was hyperostosis, mainly of the medulla of sternbrae. Hyperostosis did not occur in long-term studies in the dog and rat and has not been seen in humans treated with Cytotec.

Carcinogenesis, mutagenesis, impairment of fertility: There was no evidence of an effect of Cytotec on tumor occurrence or incidence in rats receiving daily doses up to 150 times the human dose for 24 months. Similarly, there was no effect of Cytotec on tumor occurrence or incidence in mice receiving daily doses up to 1000 times the human dose for 21 months. The mutagenic potential of Cytotec was tested in several *in vitro* assays, all of which were negative.

Misoprostol, when administered to breeding male and female rats at doses 6.25 times to 625 times the maximum recommended human therapeutic dose, produced dose-related pre- and post-implantation losses and a significant decrease in the number of live pups born at the highest dose. These findings suggest the possibility of a general adverse effect on fertility in males and females.

Pregnancy: Pregnancy Category X. See boxed **CONTRAINDICATIONS AND WARNINGS**.

Nonteratogenic effects: Cytotec may endanger pregnancy (may cause miscarriage) and thereby cause harm to the fetus when administered to a pregnant woman. Cytotec produces uterine contractions, uterine bleeding, and expulsion of the products

- Cytotec should be used in a woman of childbearing potential only if she is using effective contraceptive measures, has received oral and written warnings concerning the hazards of misoprostol, has had a negative serum pregnancy test within two weeks prior to beginning therapy, and will begin therapy only on the second or third day of the next menstrual period.

- Some patients may experience transient diarrhea, which usually resolves in about a week, or abdominal discomfort. Abdominal discomfort may persist in the absence of gastric ulceration.

of conception. Miscarriages caused by Cytotec may be incomplete. In studies in women undergoing elective termination of pregnancy during the first trimester, Cytotec caused partial or complete expulsion of the products of conception in 11% of the subjects and increased uterine bleeding in 41%. If a woman is or becomes pregnant while taking this drug, the drug should be discontinued and the patient apprised of the potential hazard to the fetus.

Teratogenic effects: Cytotec is not fetotoxic or teratogenic in rats and rabbits at doses 625 and 63 times the human dose, respectively.

Nursing mothers: See **Contraindications**. Cytotec should not be administered to nursing mothers because the potential excretion of misoprostol acid could cause significant diarrhea in nursing infants.

Pediatric use: Safety and effectiveness in children below the age of 18 years have not been established.

ADVERSE REACTIONS: The following have been reported as adverse events in subjects receiving Cytotec:

Gastrointestinal: The most frequent gastrointestinal adverse events were diarrhea and abdominal pain. The incidence of diarrhea ranged up to 40% but averaged 13% in clinical trials.

Diarrhea was dose related and usually developed early in the course of therapy (after 13 days), usually was self-limiting (often resolving after 8 days), but sometimes required discontinuation of Cytotec (2% of the patients). Rare instances of profound diarrhea leading to severe dehydration have been reported. Patients with an underlying condition such as inflammatory bowel disease, or those in whom dehydration, were it to occur, would be dangerous, should be monitored carefully if Cytotec is prescribed. The incidence of diarrhea can be minimized by administering after meals and at bedtime, and by avoiding coadministration of Cytotec with magnesium-containing antacids.

Gynecological: Women who received Cytotec during clinical trials reported the following gynecological disorders: spotting (0.7%), cramps (0.6%), hypermenorrhea (0.5%), menstrual disorder (0.3%) and dysmenorrhea (0.1%). Postmenopausal vaginal bleeding may be related to Cytotec administration. If it occurs, diagnostic workup should be undertaken to rule out gynecological pathology.

Elderly: There were no significant differences in the safety profile of Cytotec in approximately 500 ulcer patients who were 65 years of age or older compared with younger patients.

Additional adverse events which were reported are categorized as follows:

Incidence greater than 1%: In clinical trials, the following adverse reactions were reported by more than 1% of the subjects receiving Cytotec and may be causally related to the drug: nausea (3.2%), flatulence (2.9%), headache (2.4%), dyspepsia (2.0%), vomiting (1.3%), and constipation (1.1%). However, there were no significant differences between the incidences of these events for Cytotec and placebo.

Causal relationship unknown: The following adverse events were infrequently reported. Causal relationships between Cytotec and these events have not been established but cannot be excluded: aches/pains, asthenia, fatigue, fever, rigors, weight changes, rash, dermatitis, alopecia, pallor, breast pain, abnormal taste, abnormal vision, conjunctivitis, deafness, tinnitus, earache, upper respiratory tract infection, bronchitis, bronchospasm, dyspnea, pneumonia, epistaxis, chest pain, edema, diaphoresis, hypotension, hypertension, arrhythmia, phlebitis, increased cardiac enzymes, syncope, GI bleeding, GI inflammation/infection, rectal disorder, abnormal hepatobiliary function, gingivitis, reflux, dysphagia, amylase increase, anaphylaxis, glycosuria, gout, increased nitrogen, increased alkaline phosphatase, polyuria, dysuria, hematuria, urinary tract infection, anxiety, change in appetite, depression, drowsiness, dizziness, thirst, impotence, loss of libido, sweating increase, neuropathy, neurosis, confusion, arthralgia, myalgia, muscle cramps, stiffness, back pain, anemia, abnormal differential, thrombocytopenia, purpura, ESR increased.

Important note: Complete prescribing information should be consulted prior to use.

DOSAGE AND ADMINISTRATION: The recommended adult oral dose of Cytotec for the prevention of NSAID-induced gastric ulcers is 200 mcg four times daily with food. If this dose cannot be tolerated, a dose of 100 mcg can be used. Cytotec should be taken for the duration of NSAID therapy as prescribed by the physician. Cytotec should be taken with a meal, and the last dose of the day should be at bedtime.

Renal impairment: Adjustment of the dosing schedule in renally impaired patients is not routinely needed, but dosage can be reduced if the 200-mcg dose is not tolerated.

8/12/91 • P91CY6423V

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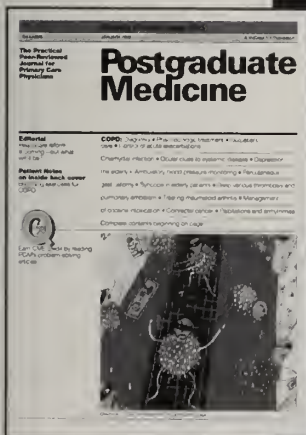
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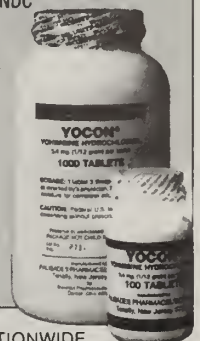
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

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Respiratory Failure and Death From HIV-Associated Myopathy

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As increasing numbers of patients with HIV infection enter the medical system, the neuromuscular problems caused by this retrovirus are better defined. Recent attention has focused on the development of myopathy and/or polyneuropathy in patients with the acquired immune deficiency syndrome. We report a patient whose initial presentation was that of progressive weakness. A diffuse HIV-induced myopathy was diagnosed that eventually resulted in ventilatory failure and death. The limited medical literature on this subject is summarized for practitioners who may encounter AIDS patients with muscle weakness.

of this muscular complication of AIDS are reviewed.

Case Report

A 40-year-old white male was unavoidably exposed to the HIV seropositive blood of a patient to whom he was providing emergency care. Three years prior to this admission, he had noted the onset of mild muscle weakness. When he developed difficulty using the muscles of his pelvis and shoulder girdles, he underwent a thorough neuromuscular evaluation at a tertiary referral center on the east coast and was found to be HIV seropositive. His muscle weakness was documented to be due to myopathy without evidence of polyneuropathy. Extensive testing was performed which led to the diagnosis of HIV-associated myopathy. Since other infectious causes of myositis had been eliminated, the patient was started on glucocorticosteroids with a dramatic improvement. He was able to return to the full activities of daily life for approximately 2 years. Attempts to discontinue or significantly taper the steroids were repeatedly unsuccessful and resulted in return of profound muscle weakness. In the 12 months prior to his admission to the Louisville VAMC, he had experienced gradual progressive muscle weakness despite maximal corticosteroid maintenance.

The patient was admitted to our facility with clinical, radiographic, and laboratory evidence of pancreatitis. Due to the hypoxemia accompanying this process, as well as the anticipated decrease in respiratory drive from the necessary pain medication, elective intubation and ventilatory support were established.

His chest radiograph showed poor spontaneous ventilatory effort, but no evidence of active infection. (Fig 1). Bronchoscopy with bronchoal-

Introduction

As of March 1990, 117,800 patients with acquired immunodeficiency syndrome (AIDS) had been reported to the Centers for Disease Control. By conservative estimate, one million people in the United States are thought to be seropositive for the human immunodeficiency virus (HIV).¹ Approximately 270,000 patients are anticipated to fulfill the criteria of the full clinical syndrome of acquired immune deficiency by 1992.^{1,2} Since many of these patients will require medical care, primary care providers in all disciplines are more likely to encounter patients with HIV-related signs and symptoms.

Successful treatment and prophylaxis against opportunistic infections has allowed investigators to begin to define the natural course of the HIV infection. Recent observations have documented the development of HIV-induced dementia, polyneuropathy, and myopathy in certain patients.^{3,4}

We present the clinical implications of HIV-associated myopathy and report an unfortunate patient who died from ventilatory failure due to inspiratory muscle weakness. The major features

veolar lavage failed to demonstrate parenchymal pathology. After 4 days of uneventful mechanical ventilation, the acute pancreatitis resolved. The ventilator was no longer necessary to insure oxygenation, although objective measurements of respiratory muscle strength suggested that the patient might benefit from continued support of the machine to rest his inspiratory muscles. With the acute abdominal crisis resolved, however, the patient extubated himself after 6 days of mechanical ventilation. He and his wife understood the significance of his severe muscle atrophy (Fig 2) and the risk of respiratory compromise, but elected to forgo further life support if his condition deteriorated. After extubation oxygenation was never a problem as indicated by a stable alveolar to arterial oxygen tension ratio (a/A ratio). Ventilation, however, became jeopardized within 36 hours after discontinuance of the ventilator. Retention of CO₂ occurred without a change in the alveolar-arterial oxygen tension gradient (Aa gradient) confirming that the patient's respiratory problem was primary hypoventilation. As CO₂ retention reached critical levels, acute uncompensated respiratory acidosis resulted with eventual cardiac arrhythmia and arrest.

Since this was the first patient known to have died of ventilatory failure from AIDS-associated myopathy, there was considerable interest in documenting the histologic appearance of the patient's diaphragms. The physicians involved in his care made special arrangements for staining these specimens for the presence of the HIV and for excluding the presence of other potential opportunistic organisms. The patient's wife, who was a physician, agreed to the postmortem examination, with the intention of securing some histologic specimens for her husband's AIDS specialists on the east coast.

Unfortunately, the university's pathology personnel at both the VAMC and the university hospital adamantly refused to perform even a limited autopsy. The opportunity for a postmortem muscle biopsy with HIV staining for comparison with the information collected at the time of his initial diagnosis of HIV-myopathy was lost. The patient was subsequently flown back to his home on the east coast for burial.

Discussion

Neuromuscular complaints are not unusual in patients with AIDS and have been attributed to a spectrum of inflammatory peripheral neuropathies.



Fig 1 — Chest radiograph shows elevated diaphragms from inspiratory muscle weakness, but no active infiltrates are present.



Fig 2 — Marked muscle atrophy of the shoulder girdle is evident after 3 years of HIV-associated myopathy.

HIV-Associated Myopathy

thies associated with demyelination and axonal loss. This process is reported to occur in as many as 40% of AIDS patients.⁵ The incidence of HIV-induced myopathy is less clear. Myopathy and myositis are less often clinically recognized as responsible for the neuromuscular problems of the AIDS patient. Although treatment of HIV seropositive individuals with antiviral drugs is associated with a unique set of neuromuscular diseases,⁶ numerous reports support the existence of a myopathy due to direct HIV infection of the skeletal muscles.^{4,7}

HIV-associated myopathy may present a problem for the primary care physician since the clinical symptoms are seldom life-threatening and, therefore, often go unreported. Weakness and some degree of muscle atrophy may be expected in all chronic debilitating diseases. Certain features are emphasized to suggest the proper diagnosis.

The clinical presentation of HIV-associated myopathy consists of nonspecific symptoms such as myalgia, fatigue, and weakness that is more proximal than distal. While motor function is diffusely impaired, sensory function is preserved. The weakness of cachexia or neuropathy is more often distal, asymmetric, and associated with sensory symptoms.

The differential diagnosis for HIV-associated myopathy must include myositis caused by opportunistic pathogens, electrolyte disturbances associated with malnutrition or malabsorption, and toxic drug effects. Especially important to the clinician is awareness that a similar clinical situation can be caused by the chronic administration of zidovudine in approximately 20% to 30% of AIDS patients treated for prolonged periods (> 50 weeks). Clinical improvement in symptoms and muscle strength generally occurs upon withdrawal of this therapy.⁸

Creatine kinase levels are usually greater than 2000 units/L. Pure myopathic findings can be documented by EMG in symptomatic patients.⁹ Therefore, elevation of serum concentrations of muscle enzymes such as aldolase and CPK along with characteristic electromyogram patterns should direct attention to myositis and away from polyneuropathy. A muscle biopsy is then critical to correct diagnosis and therapy.

The skeletal muscle lesions found in patients with HIV infection can be divided into two broad categories. The first one includes muscle changes of known etiology. This includes atrophy secondary to wasting or denervation, toxic effects of drugs, electrolyte disturbances in AIDS patients,

and direct infection of the skeletal muscle by opportunistic agents.¹⁰

The second group demonstrates lesions due to either direct or indirect effects of HIV infection on the skeletal muscle fibers. The first histologic description of HIV-induced myopathy in an AIDS patient was detailed in 1987.⁴ Biopsy findings emphasized marked variation in muscle fiber size, hyperangulation of fibers without hypertrophy, and varying degrees of sarcoplasmic vacuolization in the central zone of the involved necrotic fibers. Active degeneration and regeneration or inflammation were not prominent features.

Since the early descriptions of HIV-associated myopathy biopsies, electron microscopy has identified the presence of nemaline rods involving the type I muscle fibers in some cases. Although nemaline rods can be seen in other conditions, their abundance in biopsy samples from AIDS-associated myopathy patients is unusual and is recognized as a helpful marker in the diagnosis.^{7,11}

Biopsy findings are credible if interpreted in the absence of viral or toxoplasmal inclusions, and negative immunoperoxidase stains directed against Cytomegalovirus, Adenovirus, and toxoplasma. Negative cultures for opportunistic pathogens are imperative considering the many opportunistic pathogens that can cause an inflammatory myopathy. Surprisingly, cultures of the muscle biopsy for the HIV have been uniformly negative.⁹

Although the association between AIDS and myopathy is well established, the pathogenesis of the myopathy has not been completely worked out. Several different mechanisms may be operative. These would include direct viral infection of muscle fibers or macrophages and autoimmunity, which is observed with animal models and other retroviruses.

Direct viral infection of myocytes, long entertained as the cause of AIDS-associated myopathy, is now further supported by the discovery of perivascular macrophages within the endomysium that show positive immunostaining for HIV antigen (gp 41). Although HIV has not yet been detected within the myofibers, a role in the pathogenesis of myopathy for HIV-infected macrophages is now strongly suggested.¹²

Treatment options are limited and there is difficulty assessing response as the myopathy may resolve to varying degrees without treatment.^{13,14} Corticosteroids were extremely effective in our patient for a 2 year period. This is consistent with the experience of other investigators.^{7,15} Plasma-

pheresis has also been employed as a treatment modality since it has had some beneficial effect in other autoimmune regulated phenomenon.¹⁵ At the current time, the administration of immunosuppressants such as corticosteroids and the use of plasmapheresis must await expanded controlled trials before consensus is achieved.

Our patient had a diagnosis of HIV-associated myopathy made at a reputable tertiary referral center based on the above criteria. His response to corticosteroids is consistent with the currently proposed mechanisms of pathogenesis. To our knowledge, this is the first patient reported to die directly from this complication of AIDS. The natural course of his HIV-associated myopathy underscores the need for primary care physicians to be aware of this recently recognized, albeit rare, expression of AIDS.

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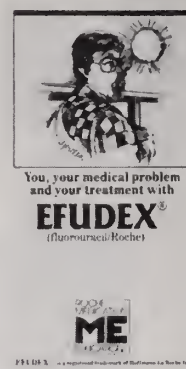
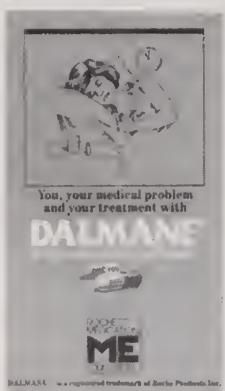
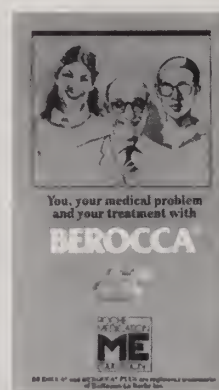
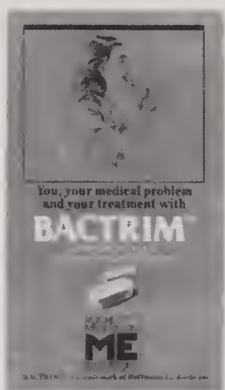


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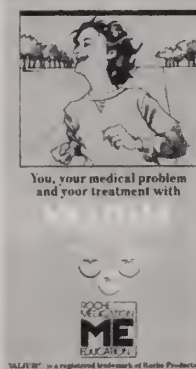
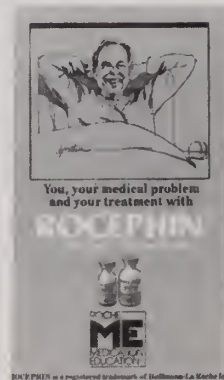
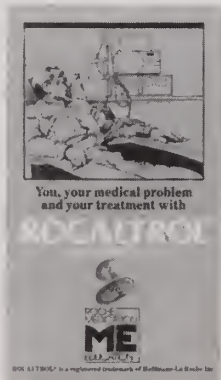
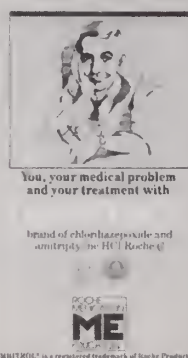
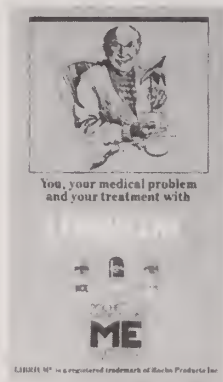


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Wilson's Disease: A Need for Early Diagnosis and Referral

Charles S. Giles, MD; Phil R. Aaron, MD

Dr Giles, Internal Medicine, and Dr Aaron, Family Practice and General Preventive Medicine, are associates at the Primary Care Center of Southern Kentucky, located in Calumbia.

Introduction

Wilson's Disease is a complex, multisystem disorder which is caused by a defect in copper metabolism. The disease was first described by Kinnier Wilson in 1912 when he described 10 patients with characteristic, neurological symptoms, cirrhosis, and gross degenerative changes in the lenticular nucleus of the brain. Since that time, it has been found that Wilson's Disease is an autosomal recessive disorder which has been attributed to a defective gene on Chromosome No. 13. The disease has a prevalence of 3 per 100,000 and an incidence of 1 in 200,000 births. The prevalence of heterozygous carriers is estimated to be approximately 1 in 100 of the population. Heterozygotes do not develop Wilson's Disease but can have some abnormalities in copper metabolism. The disease is a progressive disorder and, if untreated, has a fatal outcome. The predominant manifestations of the disease are hepatic and neurological in origin but various other organ systems are affected as well.^{3,22,36}

Case Report

A 41-year-old white male was admitted to the hospital with bradycardia, hypothermia, and purposeless movements of the upper and lower extremities associated with dystonic facial movements. The patient had a 15-year history of purposeless movements of the upper and lower extremities which were continuous and nonrhythmic in nature. These movements were also associated with dystonic facial movements of the mouth, lips, and tongue. At times, drooling of the mouth was noted as well.

Four to 5 years prior to admission, the patient's mental status had deteriorated to the point that he occasionally exhibited aggressive, violent behavior. These episodes were intermittent and were also associated with occasional episodes of hallucinations. Prior to this time, the patient's

mental capacities had apparently been intact. Previous workup had shown the patient to have a CT of the head which revealed calcification of some of the basal ganglia. The patient had laboratory performed which showed an elevated 24-hour urine copper of 40 micrograms for 24 hours, normal being less than 31 micrograms for 24 hours. Serum copper was 143 micrograms per deciliter; normal, 60 to 120 micrograms per deciliter. Calcium was decreased at 8.4 with a low albumin, ceruloplasmin 38; normal, 14 to 58 micrograms per deciliter. The remainder of the patient's SMA24 was within normal limits.

The patient was felt to have Wilson's Disease and was empirically begun on penicillamine, and after institution of penicillamine, was noted to have a decreasing hemoglobin to 8.7. White count was 5,200; platelet count, 4,000; haptoglobin, 185 — normal, 25 to 185 micrograms per deciliter; Coomb's, direct and indirect, negative. Penicillamine was discontinued at this point because of possible secondary anemia, and the patient was started on zinc sulfate. The patient responded with a decreased serum copper to 128 micrograms per deciliter and a decreased 24-hour urine copper to 18 micrograms per 24 hours. The patient's hemoglobin also improved to 12.8.

The patient's movement disorder was contained with Artane 20 mgs, qid. The patient's condition slowly deteriorated and his movement disorder eventually became unresponsive to the Artane. He presented to our hospital with symptoms of bradycardia, with heart rate down into the 30s, hypothermia with a core body temperature of 91°, and purposeless movements of the upper and lower extremities with coreiform-like, continuous movements which were nonrhythmic in nature. These movements were associated with dystonic facial movements of the face, lips, and tongue, and also with intermittent episodes of drooling. The patient was unable to communi-

cate and was not responsive to verbal stimuli. Funduscopic exam revealed a possible K-Fleischer ring at the sclerocorneal junction and the left iris was streaked with a gold-like, amber coloration. The patient's liver was small at 8 centimeters in the mid-clavicular line, and his heart was bradycardic without murmur. The patient experienced a transient episode of hypotension, unresponsive to Artane initially, and a pacemaker was placed in a lifesaving measure. Subsequent laboratory revealed the patient's white count to be normal at 4,900 without any left shift; his CPK was elevated, after placement of the pacemaker, to 260 with a 13% MB fraction. LDH was elevated, SGTP was elevated, and alkaline phosphatase was elevated. The patient subsequently elevated his blood pressure and was able to maintain a normal blood pressure with systolics of 120, even with bradycardic rates. The bradycardia was felt to be secondary to hypothermia, and the patient's temporary pacemaker was discontinued. The patient's blood cultures, sputum cultures, and urine cultures were all negative, and there were no focal signs of infection. The patient's hypothermia was felt to be secondary to possible hypothalamic involvement to Wilson's Disease. The patient's family did not wish for further invasive procedures to be instituted, and the patient subsequently died of cardiopulmonary arrest.

Pathophysiology

Wilson's Disease is a copper storage disease. In the late 1930s, it was noted that copper excess was the cause of patient symptomatology. In the 1950s, it was subsequently noted that individuals with Wilson's Disease often were markedly deficient in a serum copper binding protein, ceruloplasmin.

Individuals with Wilson's Disease ingest a normal amount of copper; however, a large amount of this copper is sequestered in the liver, probably because of defective mobilization of the copper from hepatocellular lysosomes for excretion via the bile. After years of normal elemental copper intake, the liver incurs damage from the toxic effects of copper. After the liver's ability to deal with excess copper is exhausted, it is released into the bloodstream where it affects other organs of the body.

As previously noted, most of the serum copper is normally bound to ceruloplasmin. In Wilson's Disease, this serum protein is often decreased, and it is often entirely saturated. As a

result, the excess copper becomes bound to albumin, from which copper can easily disassociate. This results in the large amount of copper often noted in the urine, which is termed hypercupriuria. Previously, it had been thought that the decreased ceruloplasmin levels were the basic etiology of Wilson's Disease. However, it is now believed that defective mobilization of the copper within the hepatic cells leads to a decreased excretion of copper and also to decreased ceruloplasmin production.^{18,35,36}

Copper Metabolism

Copper is normally secreted from the hepatocyte into the bile and excreted from the body in the feces. Because of the intrahepatic defect preventing normal copper secretion into bile, in Wilson's Disease, the liver is progressively damaged. If the liver is unable to secrete ingested copper, copper levels begin to rise in the serum. This excess copper, which is not detoxified, is then free to combine with other molecules, particularly those with sulfhydryl groups. As a result, various clinical manifestations occur secondary to copper deposition in various organ systems.^{7,8,13}

Clinical Manifestations

The signs and symptoms of Wilson's Disease usually occur between the ages of 5 and 50. Wilson's Disease normally presents in younger patients with signs of hepatic abnormalities, while in older patients, neurological signs and symptoms seem to be more predominant. Various other clinical manifestations which are a result of hepatic, neurologic, hematopoietic, renal, psychiatric, skeletal, ophthalmologic, or cardiac involvement are also noted. Most patients present, however, with predominantly hepatic, neurologic, or psychiatric manifestations.^{3,13,26,28,32}

Hepatic Forms

This is the most common mode of presentation in childhood, with the symptoms most frequently occurring between the ages of 6 and 14. The various clinical presentations include those of chronic hepatitis, juvenile cirrhosis, atypical viral hepatitis, postnecrotic cirrhosis, and fulminant hepatic failure.

Fulminant hepatitis can occur suddenly, is usually unresponsive to treatment, and is frequently fatal — particularly when accompanied with a hemolytic anemia. This course usually is

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characterized by sudden onset, associated with progressive jaundice, ascites, and hepatic failure, terminating in death.

The more common presentation is insidious in nature and usually runs a chronic course. This course is characterized by weakness, fatigue, anorexia, mild jaundice, occasional splenomegaly, and is accompanied by abnormal liver function tests. This course resembles chronic active hepatitis and is indeed indistinguishable from chronic active hepatitis.

Other patients present with the typical pictures of postnecrotic cirrhosis with a small, shrunken liver, which may be associated with other clinical symptoms including angiomas, splenomegaly, portal hypertension, ascites, and esophageal varices. Routine liver functions, in this case, may be normal even though micronodular cirrhosis is present histologically.

Any patient below the age of 30, with clinical symptoms as those described above, should be suspected of possibly having Wilson's Disease. The diagnosis is even more highly suspected if there is evidence of consanguinity in the pedigree or if there is evidence of liver or neurologic disease in other siblings.

Hepatocellular carcinoma is rarely noted in individuals with Wilson's Disease, and it is thought that its absence is possibly secondary to a protective effort exerted by the excess copper in the liver. Liver function tests, as noted above, are usually variable and when elevated are usually only minimally elevated. If the only symptoms of Wilson's Disease are hepatic in origin, then the mortality for these individuals tends to be higher than for any other clinical presentation. The Kayser-Fleischer rings usually present in patients having neurological symptoms may be absent in patients having hepatic manifestations.^{8,13,28,30,32}

Neurologic Complications

Neurologic complications of Wilson's Disease are the most common form of presentation of this illness. The neurologic manifestations occur after liver disease has occurred.

The usual *age* of neurologic symptoms is 12 to 32. Early symptoms include incoordination, tremor, dysarthria, excessive salivation, dysphasia, and mask-like faces. Resting tremor is usually the earliest manifestation of the illness. The tremors are usually generalized and are intensified by involuntary movements. Dysarthria also occurs early and may initially be present in a benign way

such as having difficulty in pronouncing multisyllabic words. Dysarthria may progress to the point of microphonia and even aphonia. Deterioration in school performance and incoordination with movement may also be noted early in the course of the illness.

As the disease progresses, other abnormalities noted include dysphagia and decreased esophageal motility as well as various movement disorders. There are three movement disorder syndromes recognized in Wilson's Disease: (1) an akinetic, rigid syndrome resembling Parkinsonism; (2) a dystonic syndrome with abnormal, involuntary movements and more sustained dystonic postures; (3) a postural and intention tremor, often with ataxia of limbs and gait, titubation of the head and dysarthria. Another late neurologic symptom noted is that of seizures. This manifestation is *often* present after institution of treatment for the disease.

Virtually all patients with neurologic manifestations of Wilson's Disease develop corneal Kayser-Fleischer rings. These are present in only two-thirds of patients with hepatic disease. These rings result from the deposition of copper in Descemet's membrane in the cornea. They are revealed with slit-lamp examination, and after treatment of the disease process, the rings can be reversed and disappear. There was only one case documented in this literature review in which a patient had neurologic symptoms but did not have any evidence of Kayser-Fleischer rings.

Pathological and neuroradiological changes in the brains of Wilson's Disease patients have been found in the lenticular nuclei, especially the putamen, but not confined exclusively to them. Involvement of the caudate nuclei, thalamus, cerebellar nuclei, pontine nuclei, and the surrounding white matter, including the internal capsule and frontal lobes, has been described. These lesions are detectable by both magnetic resonance imaging and CT scanning. The most common finding on CT scanning is that of hypodense areas in the basal ganglia. On MRI scanning, the putamen and caudate are frequently visualized as having an increased signal. In one study, all patients with a normal neurologic exam had a normal MRI, while only 1 of 19 patients with an abnormal neurologic exam had a normal MRI. CAT Scan abnormalities have been known to revert to normal after treatment. Neuropsychological testing performed on patients with Wilson's Disease almost always show motor and memory dysfunction.^{4,15,17,20,22}

Renal Disorders

The renal system is also a target of Wilson's Disease. Proximal renal tubular reabsorption is impaired in most patients, as manifested by amino aciduria, peptiduria, glucosuria, uricosuria, phosphaturia, and renal tubular acidosis. Renal injury, therefore, may at times be manifested as Fanconi's Syndrome. Most renal abnormalities disappear following treatment of Wilson's Disease.³²

Bone Disease

Skeletal changes are occasionally noted in patients with Wilson's Disease. Changes affecting the knees and wrists are frequently observed. Bone and joint pains, osteoporosis, osteochondritis, pseudofractures, bone fragmentations, osteoarthritis, osteochondritis dissecans, and renal rickets (Fanconi's Syndrome) have all been described. Surgical intervention is frequently necessary to correct bone deformities.⁶

Ocular Disorders

The eyes are the third most clinically significantly affected organ system after the liver and neurological symptoms in Wilson's Disease. Kayser-Fleischer rings, as previously described, result from deposition of copper in Descemet's membrane. They first appear as granular browned crescents in the superior corneal quadrant. These are followed by inferior crescents and eventually may become completely circumferential. Slit-lamp examination is required to ascertain the presence of these rings early in the disease. Another ocular abnormality, seen less frequently than Kayser-Fleischer rings, is the sunflower cataract. This is usually visualized with the ophthalmoscope as a disc-shaped opacity about the size of the pupillary aperture, with spokes radiating toward the lens periphery like petals of a flower. The color is usually golden, greenish, or gray. They rarely affect vision and generally disappear as the disease is treated. Kayser-Fleischer rings also usually disappear with treatment of the disease.^{6,28,32}

Psychiatric Disorders

Psychiatric disorders are a common presentation of Wilson's Disease, and a variety of psychiatric, psychological and psycho-social impairments have been reported. These include confusional states, cognitive impairment, dementia, mental

retardation, poor school performance, anxiety, depression, suicidal ideation, emotional lability, mania, schizophrenia-like states, abnormalities of behavior, psychopathic personality disorders, criminality, and alcohol abuse. The most frequent psychiatric disorders noted are those of incongruous behavior, irritability, aggression, personality change, depression, and cognitive impairment. Although schizophrenia-like states have been reported, they appear to be rare. Neuroleptic drugs may be useful in treatment of those with psychiatric manifestations, but they may have various side effects which are the same as some of the signs and symptoms of *Wilson's Disease* itself. These include liver abnormalities, pancytopenia, mask-like faces, tremor, rigidity, excess salivations, and dystonia. Thus, what may in actuality be Wilson's Disease in an advanced stage might in fact be misinterpreted as drug side effects. Therefore, neuroleptic agents should be used with these possibilities in mind.^{8,10,12,17,24}

Hemolytic Anemia

An acute hemolytic anemia may be the presenting episode in a few patients. Hemolytic anemia may be intermittent and may precede hepatic manifestations by several years or may occur concurrently with acute hepatic failure. Occasionally, hemolytic anemia is the only presenting symptom of Wilson's Disease. The hemolysis may be intravascular and accompanied by hemoglobinemia and hemoglobinuria. The Coomb's test is always negative in these instances. In any individual under the age of 20 years, Wilson's Disease should be considered if a Coomb's test negative, nonspherocytic hemolytic anemia is present.⁶

Miscellaneous Disorders

Other signs and symptoms of Wilson's Disease include cholelithiasis, renal calculi, amenorrhea, gynecomastia, and pigmentation of the nail beds.

Diagnosis

In individuals with clinical manifestations as previously described and historical factors suggestive of the possibility of Wilson's Disease including European/Jewish extraction, ancestral consanguinity, previous episodes of unexplained jaundice or abdominal pain, and symptoms suggestive of endocrinopathy, the eyes should be examined for evidence of Kayser-Fleischer rings

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and a ceruloplasmin level should be performed. If such a patient has Kayser-Fleischer rings and a low ceruloplasmin concentration — less than 20 mgs per deciliter — then that individual does have Wilson's Disease. In individuals who have Kayser-Fleischer rings with a normal ceruloplasmin level, a liver biopsy to measure hepatic copper content is required to make the diagnosis. In untreated individuals with Wilson's Disease, the hepatic copper concentration is markedly in excess of 250 micrograms per gram of dried hepatic tissue. Occasionally, individuals with neurologic Wilson's Disease may have hepatic concentrations less than 250 micrograms per gram of hepatic tissue but more than 100 micrograms per gram dry weight hepatic tissue, with normal being less than 50 micrograms per gram of dry weight. In these individuals, radioactive copper studies may be used as a final diagnostic method. This technique involves the ingestion of a radioactive copper with serum concentrations measured sequentially over 48 hours after the ingestion. Normal patients show an initial maximum concentration 1 to 2 hours after ingestion, then the level falls. Two to 4 hours later, subjects without Wilson's Disease show a subsequent, progressive rise in serum copper concentration as it is incorporated into ceruloplasmin. In patients with Wilson's Disease, this secondary rise in serum copper concentration is absent. Other tests supportive of but not diagnostic of Wilson's Disease include an elevated urinary copper level of more than 100 micrograms per 24 hours of collection and a low total serum copper level.

Kayser-Fleischer rings are not found in all patients with Wilson's Disease but are almost always found in individuals with neurologic or psychiatric manifestations of Wilson's Disease. Kayser-Fleischer rings are not specific for Wilson's Disease and have been reported to occur in a variety of other liver diseases including primary biliary cirrhosis, chronic active hepatitis, and cryptogenic cirrhosis. The concentration of ceruloplasmin is lower than normal in 95% of individuals with Wilson's Disease. A low ceruloplasmin level is not specific for Wilson's Disease, either. The level may be low in any other illness which causes severe protein loss or may be low as a result of active liver disease for other etiologies. In addition, the ceruloplasmin level may be increased to normal in individuals with Wilson's Disease who are pregnant or in a number of pathological states including infections, certain active non-Wilsonian liver disease, rheumatoid ar-

thritis, some neoplastic disorders, and a number of conditions associated with inflammatory or necrotic changes.

CT or MRI scanning can also be used to support the diagnosis of Wilson's Disease. Individuals often show abnormalities of cortical atrophy and ventricular atrophy with low-density areas noted in the basal ganglia on CT and intensified areas of signal in the basal ganglia on MRI scanning. Finally, two other groups should be considered in the diagnosis of Wilson's Disease — heterozygotic individuals as well as siblings and cousins of known patients with Wilson's Disease. Heterozygotes should be worked up in the same manner as one would any individual suspected of having Wilson's Disease, and although these individuals may have abnormalities in copper metabolism, they will not fit the criteria of Wilson's Disease once the step-by-step diagnostic method is used. All siblings and cousins of known patients with Wilson's Disease should be screened with a slit-lamp exam to search for evidence of Kayser-Fleischer rings and with a serum ceruloplasmin level.^{5,8,18,19,32}

Treatment

The standard therapy in Wilson's Disease is D-Penicillamine. This drug chelates copper and increases urinary excretion of copper. Treatment may be started at a daily dose of 1.2 grams, given in four divided doses. The dosage may eventually need to be increased to as high as 2, or even 3, grams daily to achieve a negative copper balance. Penicillamine is best taken on an empty stomach since food reduces its absorption. Improvement during treatment is slow but usually occurs within 3 months. In some individuals however it may be 6 months to a year before noticeable change takes place. Foods known to contain large amounts of copper, such as liver, nuts, chocolates, shellfish, and mushrooms, should be avoided in the patient's diet.

It is essential to obtain biochemical evidence of successful decoppering. Therefore, before penicillamine is started, 24-hour collections of urine for copper should be obtained in order to monitor urinary excretion of copper. After starting penicillamine, the 24-hour urinary copper excretion will increase from the initial several hundred micrograms to 2 to 3 milligrams. The concentration of free copper in the serum also will slowly begin to fall. Total serum copper and ceruloplasmin concentrations, 24-hour urinary copper excre-

tion, full blood counts, and routine urinalysis are required at least weekly during the first month of treatment. Thereafter, the patient should be assessed once a month for the first year of treatment and at least yearly thereafter. As the urinary excretion of copper *falls* and the free serum copper level *falls*, signs of clinical improvement slowly begin to appear. This may be manifested by the fading of Kayser-Fleischer rings, clearer speech, decreased tremor, or a clearer mentality. Serum ceruloplasmin concentration may fall or rise during the treatment period. Once individuals are adequately treated, they will usually have free serum copper levels of less than 0.1 milligram per liter and a 24-hour urinary copper excretion of less than 0.5 milligrams. This treatment will maintain asymptomatic patients in good health and will lead to improvements in symptoms and signs of liver and brain disease in the affected individuals.

The major problem with penicillamine is continued hepatic or neurological deterioration despite biochemical evidence of decoppering. Indeed, many individuals with neurological symptoms will initially become worse before they improve. Other frequent major problems are those of toxic side effects. A significant number of individuals with Wilson's Disease will develop early side effects from the first month of treatment. The commonest are those of fever, rash, and lymphadenopathy. Penicillamine should be stopped if these reactions occur. The penicillamine can then be restarted along with a covering dose of steroid. The reintroduced penicillamine should be started at a much lower dose. A more serious early reaction is that of marrow depression and aplastic anemia. This is an indication to switch to an alternative agent. Late complications of penicillamine can include rashes, proteinuria and Nephrotic Syndrome, Systemic Lupus Erythematosus-like Syndrome, Goodpasture's Syndrome, and myasthenia gravis. Individuals on penicillamine also may develop pyridoxine deficiency, and when large doses are given, Pyridoxine supplements of 25 mgs a day should be given.

If the patient tolerates penicillamine and achieves adequate biochemical parameters, then the penicillamine should be reduced to the lowest dose possible in the range of 500 mgs to 1 gram per day to continue to maintain adequate biochemical parameters. This maintenance dose should then be continued for the patient's entire lifetime. *If penicillamine is not tolerated clinically, then Triethylene Tetramine Dihydrochloride,*

equally effective, should be tried. The usual starting dosage is 800 mgs, three times a day. This agent is also a decoppering agent and like penicillamine has numerous side effects.

Another treatment alternative is elemental zinc. Zinc acetate 50 mgs, three times a day, given between meals, inhibits the gastrointestinal absorption of copper. The successful decoppering of zinc may be monitored by measurements of free serum copper concentrations. Zinc therapy should be considered in individuals who have not had a response to penicillamine or who have had a serious or irreversible reaction to penicillamine or Triethylene Tetramine Dihydrochloride.

Finally, in the rarer patient, hepatic transplantation may be indicated in those who present with the fulminant, hepatic form of the disease who fail to improve with penicillamine therapy, or those who develop fulminant hepatic failure and hemolysis after stopping decoppering therapy. After liver transplantation, the metabolic defect is corrected and these individuals will not require further penicillamine therapy.^{22,29,30,33,35}

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Platypnea, Orthodeoxia and Cirrhosis

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It is estimated that 15% to 45% of patients with cirrhosis of the liver are hypoxemic without apparent lung or heart disease.¹ This report reviews the association of orthostatic hypoxemia with hepatic dysfunction.

Introduction

Dyspnea that occurs in the upright position, but is relieved in the supine position, is termed platypnea. This symptom, first recognized in 1949² and formally defined in 1969,³ often occurs with an accentuated decrease in arterial oxygen tension in the erect position. This latter phenomenon, recorded in 1976,⁴ is properly referred to as orthodeoxia. Clinicians are often unfamiliar with these terms, despite their common occurrence in patients with hepatic cirrhosis.

We present a patient with severe orthodeoxia and platypnea associated with cirrhosis of the liver secondary to non-A, non-B hepatitis and provide a current review of this unusual cause of hypoxemia.

Case Report

R.R., a 69-year-old white male, was admitted for workup of dyspnea on exertion, which had been progressively worsening over the previous 12 months. He had no previous history of pulmonary disease. He denied nocturnal paroxysmal dyspnea. He felt more comfortable in the supine position and related his dyspnea to standing and walking. He denied any chest discomfort.

His past history was remarkable for atherosclerotic coronary artery disease. This had been diagnosed 7 years earlier by cardiac catheterization which had been prompted by chest discomfort on exertion. He had not sustained myocardial infarction. Coronary artery bypass grafting of his two affected coronary arteries was successful. His

immediate recovery was uneventful. Subsequently, the patient was discovered to have contracted non-A, non-B hepatitis from the blood transfusions required during his cardiac surgery. Eighteen months prior to the current evaluation, cirrhosis of his liver was confirmed by transcutaneous hepatic needle biopsy.

The patient had a minor history of cigarette smoking and had quit tobacco use 40 years earlier. He did not consume alcoholic beverages. His home medications included hydralazine for hypertension and furosemide 20 mg as needed for edema in the leg from which the saphenous vein had been harvested.

At the time of admission his blood pressure was 140/70 mm Hg. His heart rate was 92 bpm in a regular rhythm. His respirations were not labored with a respiratory rate of 18/min. His oral temperature was measured as 97.2°F. Except for a well healed sternotomy scar, his cardiopulmonary examination was normal. Examination of the abdomen was normal and no organomegaly was present. There was mild swelling of the right lower extremity, which also bore the surgical scars of saphenous vein removal.

The admission laboratory was normal except for an elevated hemoglobin of 17.2 gm/dl with a hematocrit of 49.1. A supine room air arterial blood gas analysis confirmed a PaO₂ of 51 torr, a PCO₂ of 27 torr, a pH of 7.47 affording 88.2% saturation of his hemoglobin and an O₂ content of 20.5 vol%. The calculated Alveolar-arterial oxygen tension gradient was widened to 65 torr (5–20 nl) with an estimated venous admixture of 37%. On 5 liters of supplemental oxygen delivered by nasal cannula, PaO₂ could be increased to 63 torr with 93% hemoglobin saturation. His hyperventilation persisted.

The chest radiograph was normal except for the wire sutures from his earlier coronary artery bypass surgery. Spirometry failed to demonstrate

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Table 1. The arterial oxygen tension changes with position in the patient with cirrhosis of the liver on an FIO₂ of 40%.

	Oxygen tension PaO ₂	Oxyhemoglobin saturation
Supine on back	63 mm Hg	93.4%
Supine on right side	63 mm Hg	93.4%
Supine on left side	61 mm Hg	93.4%
Sitting up on side of bed	50 mm Hg	87.9%
Standing	43 mm Hg	82.6%

evidence of airflow obstruction. Static lung volumes measured by the helium dilution method found his total lung capacity decreased to 77% of his predicted value and his vital capacity to be decreased to 59% of his predicted. The flow-volume tracings were consistent with a restrictive process. His diffusion capacity for carbon monoxide (DLCO) was decreased to 60% of his predicted value.

Electrocardiogram and echocardiogram were normal except for an occasional premature ventricular complex of unifocal origin.

Arterial blood gas analyses were performed via a radial arterial line with the patient in the supine, sitting, and standing positions while receiving 40% FIO₂ by Venturi mask (Table) and significant orthodeoxia was confirmed.

Discussion

Hepatic cirrhosis, an irreversible process of fibrosis and nodular regeneration of the liver parenchyma, is the most prevalent type of chronic liver disease in the United States. In 1884, Fluckiger⁵ described a woman with severe hepatic cirrhosis who had cyanosis and clubbing of her digits without cardiopulmonary dysfunction. More recently, hypoxemia has been described in cirrhosis due to alcohol,⁶ hemachromatosis,⁷ primary biliary cirrhosis,⁸ cryptogenic cirrhosis,⁹ and following hepatitis.¹⁰

Various pathophysiologic mechanisms have been proposed to explain the hypoxemia associated with cirrhosis. Historically, a decreased affinity of hemoglobin for oxygen with a rightward shift of the oxyhemoglobin dissociation curve¹¹ seemed a likely explanation. This change in oxyhemoglobin affinity in cirrhotics is due to increased 2,3-diphosphoglycerate within the eryth-

rocyte. Subsequent studies indicate that the change in oxyhemoglobin affinity alone is not sufficient to explain the degree of observed hypoxemia.¹²

Hypoventilation can be eliminated as a cause of hypoxemia since cirrhotic patients generally hyperventilate¹³ and should increase their arterial partial pressure of oxygen.

Limitation in the diffusion of oxygen from alveoli to the capillary blood is another theoretical cause of hypoxemia in cirrhotic patients. The presence of dilated intrapulmonary arterioles and capillaries are well documented at post mortem exam. These vessels often measure 60-80 μ m with normal vessels measuring 8-15 μ m. The widened distance for diffusion and the layering of the erythrocytes retards end-pulmonary capillary oxygen tension from reaching equilibrium with the alveolar gas.

As many as 20% of cirrhotics have an abnormal diffusion capacity for carbon monoxide.¹⁴ Those patients with severe liver dysfunction often present with a hyperdynamic cardiovascular system. Vascular resistances are reduced due to pulmonary and systemic vasodilatation, augmenting cardiac output. These hemodynamic changes potentially decrease transit time of erythrocytes through the capillary system of the lungs and may exaggerate the pre-existing diffusion disequilibrium. This mechanism remains controversial as other studies have shown that a diminished diffusion capacity plays only a minor role in explaining mild to moderate hypoxemia.⁹ Abnormal diffusion of oxygen is not currently believed to be a major factor in the cirrhotic patient with severe hypoxemia.¹⁵

Many investigators believe arteriovenous shunting is the primary reason for the hypoxemia associated with liver cirrhosis. This is supported by lung ventilation-perfusion scans,¹⁶ contrast echocardiography¹⁷ and anatomic studies.¹⁸ Small intrapulmonary arteriovenous communications within the lung parenchyma or the pleural surface form true anatomic shunts. These abnormal communications allow radionucleotides to bypass the pulmonary capillary beds and lodge in distant organs such as the brain and kidneys. Such true shunts, however, are uncommon.¹⁷

Anastomoses between the portal and pulmonary vasculature are described occasionally¹³ in patients with cirrhosis and portal hypertension.¹ These communications are unlikely to contribute to the hypoxemia observed in cirrhotic patients since the portal circulation has an inherent rela-

tively high partial pressure of oxygen and would, therefore, require a much greater blood flow than reported through these small anastomoses to accomplish hypoxemia. Further evidence that these portal-pulmonary communications contribute little is that cirrhotic patients remain hypoxemic after these shunts have been surgically abolished.¹⁹

Finally, ventilation-perfusion mismatching may cause the hypoxemia associated with hepatic cirrhosis. Several mechanisms have been proposed. In patients with cirrhosis and no clinical, radiologic, or spirometric evidence of cardiopulmonary disease, premature closure of airways during resting respiration has been demonstrated.¹³ Gas trapping due to mechanical compression of small airways could lead to microatelectasis and ventilation-perfusion inequality. Other authors,¹⁸ however, found no consistent relation between premature closure and the degree of hypoxemia. Additional mechanical factors have been considered. Elevation of the hemidiaphragms by tense ascites can lead to atelectasis and, therefore, areas of low ventilation-perfusion ratio.¹³ Pleural effusions, found in 5% to 10% of cirrhotic patients, with or without clinical evidence of ascites of other intrathoracic disease process may also worsen gas exchange.²⁰ Still, hypoxemia is described in cirrhotics without ascites or pleural effusion. There must therefore be other mechanisms involved that produce a ventilation-perfusion inequality.

Cirrhotic patients have either a normal or slightly muted or an absent pulmonary vasoconstrictive response to induced hypoxemia.²¹ Patients whose pulmonary vasculature responds to hypoxic challenge have less hepatic dysfunction, normal pulmonary and systemic hemodynamics, and normal gas exchange. Patients with blunted hypoxic pulmonary vasoconstriction are characterized by worse liver disease, pulmonary and systemic vasodilatation, increased cardiac output, and hypoxemia.⁹ The picture evolving is that ventilation-perfusion abnormalities in mild to moderate hepatic dysfunction result from perfusion of alveoli having a low ventilation-perfusion ratio due to a muted hypoxic pulmonary vasoconstriction.^{9,10,15} As liver disease progresses, the pulmonary vasculature no longer responds to hypoxic stimuli resulting in worsening ventilation-perfusion inequalities, shunts, and hypoxemia.¹⁵

With a predilection for dilated arterioles and capillaries in the bases of the lung, there is a preferential blood flow to the dependent portions

of the lungs with a decreased perfusion to the upper lung fields, when the patient arises from a supine position. This phenomenon increases both the physiological dead space and the work of breathing and platypnea follows.⁶ Orthodeoxia develops due to the absent or muted pulmonary vasoconstrictive response to hypoxia.¹⁹ The contribution of the widened distance for diffusion of oxygen is minor.

The diagnosis of orthodeoxia in cirrhosis depends on a clinical awareness of the symptoms and a high degree of suspicion. Orthodeoxia is easily demonstrated by supine and erect arterial blood gases or oximetry. Oximetry may be misleading, however, in icteric patients since bilirubin may interfere with oximetric accuracy. When orthostatic desaturation is documented, further evaluation is indicated. A radionucleotide lung perfusion scan can document a true shunt by demonstrating increased tracer activity in the brain and kidneys. The perfusion scan also allows semiquantitative estimate of the percent of arteriovenous shunting. It does not however identify the shunt's location. Orthostatic contrast echocardiography has been used to prove both intracardiac and intrapulmonary shunts.²² The ease of performing echocardiography allows for successful diagnosis even in debilitated patients and usually avoids the need for cardiac catheterization. Occasionally a catheterization may be required when the echocardiography is ambiguous or if there is a need to assess the coronary artery or cardiac anatomy or to measure intracardiac or pulmonary artery pressures.²³ Supine and upright cardiac catheterization is used to document and quantitate suspected intracardiac defects, but there are technical and logistic problems to overcome with an upright cardiac catheterization. Angiography of other vascular structures is apt to be of little benefit since portal-pulmonary anastomoses are rare and add little to the shunting process.

If an anatomical shunt is discovered, such as a patent foramen ovale or a large arteriovenous malformation, consideration may be given for surgical treatment or embolotherapy. More commonly, functional or microanatomic intrapulmonary shunts are present and management is more difficult.

Care must be taken in these patients with severe liver disease and hypoxemia to avoid drugs that may decrease cardiac output or cause further vasodilatation that may worsen the clinical condition and gas exchange. Isosorbide dinitrate, vasopressin, and somatostatin have been used in the

Platypnea, Orthodeoxia and Cirrhosis

treatment of portal hypertension and esophageal variceal bleeding. These drugs, however, worsen arterial oxygenation.

Propranolol has been proposed in the treatment of esophageal bleeds as well. Propranolol induces a significant decrease in the FEF 25-75, an insignificant increase in the arterial partial pressure of oxygen, and a small but significant improvement in the alveolar-arterial oxygen gradient.²⁴ The mechanism for this paradoxical benefit is unknown. Almitrine bimesylate, an experimental drug, has been shown to improve ventilation-perfusion matching in patients with chronic obstructive pulmonary disease.²⁵

Severe hypoxia has been considered an absolute contraindication for liver transplantation. Also, there are reports in which liver transplantation did not reverse pulmonary dysfunction even with normal hepatic graft function.^{1,19} A recent study,⁸ however, showed a normalization of arterial oxygenation and a decrease in shunt fraction after hepatic transplantation for primary biliary cirrhosis. This study challenges the conventional notions suggesting that more data on the management of patients with pulmonary complications of chronic liver disease and liver transplantation are needed.

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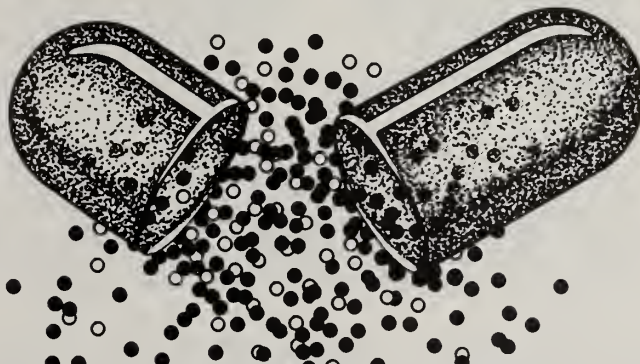
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3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H₂-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H₂-receptor antagonists.

Precautions: General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix[®] may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method. PV 2093 AMP [101591]

Additional information available to the profession on request.



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APRIL

24-25 — Contemporary Pediatrics for the Practicing Physician; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

MAY

1-2 — Annual Meeting, The Virginia Society of Otolaryngology-HNS; Boar's Head Inn, Charlottesville, VA. Contact: Donna Scott, 4205 Dover Rd, Richmond, VA 23221; 804/353-2721.

8-9 — Diabetes, Lipids and Obesity: Critical Assessment of Risk Factors; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

16 — Management of Retinal Vascular and Macular Disorders; Radisson Plaza Hotel, Lexington, KY. Course Directors: William Wood, MD, and Rich Isernhagen, MD. Contact: Kay Montgomery, The Center for Advanced Eye Surgery at Humana Hospital-Lexington at 606/268-3754.

17-22 — 23rd Family Medicine Review, Session II; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

JUNE

1-3 — 60th Assembly of the Southeastern Surgical Congress, Westin Peachtree Plaza Hotel, Atlanta, GA. Contact: Roger Sherman, MD, 69 Butler St Southeast, #314, Atlanta, GA 30303; 404/221-0570.

11-13 — 37th Great Smoky Mountains Pediatric Seminar; Park Vista Hotel, Gatlinburg, TN. Contact: Continuing Medical Education, 1924 Alcoa Highway, D-116, Knoxville, TN 37920; 615/544-9190.

AUGUST

8-14 — 11th Annual Scientific Meeting and Exhibition of the Society of Magnetic Resonance in Medicine; Berlin, Germany. Contact: SMRM, 1918 University Avenue, Suite 3C, Berkeley, CA 94704; 510/841-1899; FAX 510/841-2340.

SEPTEMBER

3-5 — Perinatal Medicine; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

25-26 — 5th Annual Rehabilitation Management for the Primary Care Physician; Radisson Plaza Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

OCTOBER

25-30 — 23rd Family Medicine Review, Session III; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

NOVEMBER

8-12 — 96th Annual Meeting of The American Academy of Ophthalmology; Dallas Convention Center. Contact: The American Academy of Ophthalmology, Meetings Dept, PO Box 7424, San Francisco,

To Empower With the Gift of Hope

Can you remember that one marvelous professor that came into the lecture hall in medical school and spoke about kindness? In my case he was an elegant gentleman. He was the division chairman for many years. He was well published. He held his associates, students, and residents to rigorous standards. But what you remember most about this professor was that he was a kind and caring man.

It was among our first days in the hospital. For the first time, we felt like "real docs." It was our moment of truth. We were to take all that we had memorized over the last 2 years and bring it to bear on each point of our soon to be patients' care. We read every spare moment. Our minds were swimming with the details of the salient futures of the diseases we were about to encounter: patient complaints, physical findings, pertinent laboratory results, appropriate medical and surgical treatment options, and of course, the morbidity and mortality statistics associated with the natural course of the disease, the course altered by the therapeutic regimen, and the therapeutic regimen itself.

We sat at rapt attention. We wore our crisp white jackets for the first time. Our names had been neatly sewn above the pockets which were bulging with pens, spare pens, and markers. In our side pockets were pocket size *Manuals of Medical Therapeutics* or *Surgical Intervention*, and our own handwritten, pocket-size binders beginning to fill with the details and caveats of diagnosis and management of all the diseases we were about to see.

Into this setting walks this distinguished professor. We readied ourselves for the pearls he was undoubtedly about to share regarding

“He suggested that we always leave the patients with hope, because who could know the value in healing of hope? . . . He helped us to understand that to care was the first step in caring for a patient.”

diagnosis and management of the patients that were about to become ours.

And he spoke of human kindness.

His hands were in both pockets brushing back both sides of his jacket. He walked about the stage as he discussed hope and kindness. He used the podium simply as a place to rest one elbow on occasion.

He suggested that we always leave the patients with hope, because who could know the value in healing of hope? Out of a flurry of facts and figures, statistics and likelihoods, came this kind and gentle man who caused us to slow down for a moment and think about the *patients*, not the diseases. He helped us to understand that *to care* was the first step *in caring* for a patient.

And so it was with great interest that years later I shared in the care of a patient with this kind man. Now there were no 5-year survival rates described for this patient's condition. Some texts referred to 6-month survival, others only cited how highly incurable the condition was. Little was written about long-term sequela or treatment of sequela because too

few survived to develop sequela. The patient was informed of this, but my kind professor, in his discussions with the patient, approached his inquiries about prognosis differently. He said that "No one could know" and "It's true that the statistics aren't good, but there's no way we can know who will be among the survivors. It could be you."

And so he opened this patient's door when all others around him wanted, perhaps unintentionally, to close it off. All others around him wanted to tell him the truth, "set the record straight," clear their own conscience, "do the right thing" . . . tell him how dismal the odds were.

At first I wondered if *he* had told the patient the truth. But 6 years later as I had the pleasure of enjoying lunch with this patient and watching him enjoy playing with his three most recent grandbabies, I knew ever more surely how he had been the *only one* to tell him the truth. Moreover, his telling him the truth had empowered him with the gift of all the hope necessary for him to achieve the gift of life.

Our statistics truly are open to interpretation, and it is in our presentation of these statistics to our patients that we have the ability to empower those so positively inclined to continue the fight to be enabled to do so. No greater or more persuasive testimony to the power of positive thinking have I experienced than this. And when we might fear that there is little we can do, *the very least* we can do is to be sure that we do not take away that which we are empowered to nurture, namely hope, or the power of positive thinking, or the force of optimism in life, however you wish to think of it.

Martha Keeney Heyburn, MD

PHYSICIAN OPPORTUNITY

The Department of Orthopaedics and Rehabilitation and the Ability Assessment Center of Vanderbilt University Medical Center have an immediate opening for a physician who is interested in musculoskeletal disorders and occupational medicine. The successful applicant must have a MD degree and a valid Tennessee medical license. Additional training in one of the following specialties would be desirable: Internal Medicine, Family Practice, Occupational Medicine, Physical Medicine, Rheumatology. In addition to patient care opportunities, involvement in clinical research and administrative responsibilities are possible. Please send curriculum vitae and three references to:

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AKMA *Connections*

The AKMA Convention — Our Spring Connection!! AKMA members from throughout Kentucky will gather in Owensboro April 20-22 for our Annual Meeting. This meeting is our opportunity to share and celebrate the accomplishments of this past year and to make our transition to the next auxiliary administration. All spouses of KMA members are invited and encouraged to attend this informative and fun meeting.

Every county auxiliary will have the opportunity to report on the activities of their organization and to share the success of their projects that have served their communities. State chairmen will also discuss the progress made through our legislative activities, our health promotion, and our fundraising efforts for AMA-ERF.

Sherry Strebel, AMA Auxiliary President, will be our special guest and speaker. Mrs Strebel will be presenting information on projects that have been implemented with the AMA with a special focus on family violence. Past state presidents, county presidents, and county presidents-elect will be honored during the meeting.

Owensboro will be abloom in April, and there are several activities planned that will give all attendees an opportunity to enjoy our beautiful city. The members of the Daviess County Auxiliary are anxious to greet you and to share their Southern hospitality. Events scheduled include

a tour and tea in an historic home, a walking tour of downtown Owensboro, a reception at a quaint bed and breakfast, a preview of our soon-to-be opened fine arts center (debut September 12, 1992), and a shopping tour.

The culmination of the meeting will be our connection to our future leadership. The 1992-93 officers will be installed by AMA Auxiliary President Sherry Strebel. The 1992-93 leadership team is composed of:

President

Beryl Dodds, Hopkins County

President-Elect

Gloria Griffin, Jefferson County

1st Vice President

Sugar Slabaugh, Fayette County

Central Region Vice President

Angela Watson, Jefferson County

Eastern Region Vice President

Marla Vieillard, Boyd County

Western Region Vice President

Mary Jo Bauer, Hopkins County

Recording Secretary

Cheryl Houston, Daviess County

Treasurer

Barb Hausladen, Northern Kentucky

Be a part of the auxiliary "Connection"! Be a part of the Auxiliary link to medicine and join us in Owensboro for a funfilled time together.

Sam Blackstone
AKMA President

PEOPLE

KMA President-Elect **William B. Monnig, MD**, Covington, has accepted an appointment as the AMA alternate representative to the Joint Commission on Accreditation of Healthcare Organizations Hospital Accreditation Program Professional and Technical Advisory Committee for a 1-year term which expires December 31, 1992.

James F. Glenn, MD, Lexington, has been elected president of the International Society of Urology (Societe Internationale d'Urologie). He is chairman of the Council for Tobacco Research, New York, executive director of the Markey Cancer Center at the University of Kentucky, and professor of surgery at the University's College of Medicine.

Jesse H. Wright, MD, and **R. John Ellis, Jr, MD**, are co-presidents of the medical staff of the Alliant® Health System adult hospitals, Norton and Methodist Evangelical. **Marjorie R. FitzGerald, MD**, is the secretary-treasurer. Members-at-large are **Janet Wygal, MD**, and **Mark E. Petrik, MD**. **Henry D. Garreston, MD**, is past-president, Norton Hospital, and **Paul A. Fleitz, MD**, is past president, Methodist Evangelical Hospital.

Stephen P. Wright, MD, has been elected president of the Kosair Children's Hospital Medical Staff. **Toni M. Ganzel, MD**, is the president-elect and **Sue Ann Cutliff, MD**, is the secretary-treasurer. Members at large are: **Joseph A. Clan, Jr, MD**, **Michael B. Foster, MD**, and **Margie R. Joyce, MD**. **Hirikati S. Nagaraj, MD**, is the past-president.

The University of Louisville has announced the appointment of **Richard N. Garrison, MD**, as acting associate dean and acting assistant

vice president of Veterans Administration Medical Center.

Robert J. Dempsey, MD, professor of neurosurgery at the University of Kentucky, presented findings of a study linking a causal connection between the amount of tobacco smoked, the thickness of fatty plaque clogging arteries to the brain, and the likelihood of stroke at a meeting of the American Heart Association's 17th International Joint Conference on Stroke and Cerebral Circulation in Phoenix, Arizona. Dr Dempsey is director of the Stroke Program Center of Excellence at UK's Sanders-Brown Center on Aging.

The KMA Resident Physician Section met on January 28 and elected the following officers: President — **Sheryl Schneider, MD**, Louisville; President-Elect — **Baretta Casey, MD**, Madisonville; Chairperson — **David Butler, MD**, Louisville; AMA-RPS Delegate — **William Hal Skinner, MD**, Lexington; KMA Delegate — **Vince Tanamachi, MD**, Edgewood; Alternate AMA Delegate — **Judy Linger, MD**, Lexington; Alternate KMA Delegate — **Amy Haney, MD**, Edgewood; and Secretary/Treasurer — **Karl Schmitt, MD**, Edgewood.

UPDATES

Robert Wood Johnson Foundation Awards \$2.5 Million Curriculum Grant to UK College of Medicine

The Robert Wood Johnson Foundation has awarded a \$2.5 million grant to the University of Kentucky College of Medicine to institute sweeping changes in the way it educates physicians. UK is one of eight US medical schools chosen from a field of 12 to participate in the Foundation's "Preparing Physicians

for the Future: A Program in Medical Education" initiative. In addition to UK, grants were awarded to: Johns Hopkins University School of Medicine, Yale University School of Medicine, University of Hawaii John A. Burns School of Medicine, University of Rochester School of Medicine and Dentistry, Columbia University College of Physicians and Surgeons, Oregon Health Sciences University School of Medicine, and University of New Mexico School of Medicine.

The grant will fund programs designed to produce physicians who are "high tech" and "high touch" — closely attuned to patient care and capable of managing the ethical and financial decisions being created by rapid advances in medical technology. The new curriculum will focus on primary care, wellness and prevention, a range of social issues related to health care, cost containment, and computer-based medicine. Changes in the way classes are taught will involve fewer large lectures and more small group learning sessions to encourage a problem-solving approach to medical education.

"This is a well deserved honor for the University of Kentucky College of Medicine and it highlights nationally progress we are making in Kentucky in both education and health care reform," said Kentucky Governor Brereton C. Jones. "This grant impacts both of these vital services in our state. Kentucky has already made great strides in education reform and it is our goal to become a national leader in health care as well."

"This grant provides the University of Kentucky with national recognition," said UK President Dr Charles T. Wethington. "It is an endorsement of the University's mission to produce first-class doctors for the Commonwealth of Kentucky."

"Health care has changed dramatically," said UK Medical Center

Chancellor **Dr Peter P. Bosomworth**. "The Medical Center is committed to growing and changing in response to those needs. This grant allows us to concentrate on innovations that will prepare students to practice medicine in the 21st century."

Dr Emery A. Wilson, dean, UK College of Medicine, commended the steering committee and College of Medicine faculty who worked to develop the new curriculum.

"We will be moving forward with curriculum changes that encourage more interaction between the basic and clinical sciences throughout all 4 years of medical school," he said.

"The highly technical environment in which most medical education occurs makes it difficult to prepare students for primary care medicine. We can better serve our students and ultimately the people of Kentucky by turning out doctors who have a realistic approach to medicine."

"This initiative recognizes the need for more primary care physicians," said **Dr H. David Wilson**, UK College of Medicine associate dean for academic affairs. "Our mission is to produce physicians who possess the caring attitude we all want in a family doctor and yet understand the ever-improving technology and how to use it in a cost-effective way."

Changes in all 4 years of the curriculum will be in effect by fall 1994. An example is a new requirement that first-year students spend time with practicing pediatricians, internists or family practice doctors to get a closer perspective of primary care medicine and the doctor/patient relationship outside the hospital setting.

Another change would require students to take a course called "The Healthy Human" focusing on nutrition, lifestyle, state of mind, stage of life and other important factors in preventing disease and maintaining good health. Besides a mandatory community service requirement,

students will examine social issues including AIDS, teen pregnancy, spouse abuse, and substance abuse in a course called "Physicians, Patients, and Society."

To familiarize future doctors with the national computerized data bases that are becoming more and more a part of the medical profession, they would be encouraged to do more independent study at computer terminals.

The Foundation was established by the late Robert Wood Johnson, who built Johnson & Johnson into a worldwide health and medical care

company. Since being established as a national foundation in 1972, it has awarded more than \$1 billion in grants.

Drug Abusers and Doctor Shoppers

The Jefferson County/Louisville Metropolitan Narcotics Division and the Kentucky State Police have requested that KMA alert its membership to an increasing number of drug abusers and/or doctor shoppers who are obtaining narcotic



AKMA Past President Betty Schrodt, Louisville, recently attended the annual meeting of the Southern Medical Association Auxiliary in Atlanta, Georgia. Mrs Schrodt serves the SMA Auxiliary as State Councilor of Kentucky. As Councilor, she is involved in policy making as she serves on the SMA Auxiliary Board of Directors. In addition, Mrs Schrodt represents Kentucky at all SMA Auxiliary functions and shares pertinent SMA Auxiliary information with members in Kentucky. Mrs Schrodt (R) is pictured with Roberta Barnett, SMA Auxiliary President, and Gwyn Parson (L), Vice-Councilor for Kentucky.

prescriptions from physicians. These individuals are fraudulently obtaining prescriptions from physicians by faking symptoms. The "patients" are obtaining prescriptions simultaneously from several doctors. The aforementioned police departments have advised that if you are suspicious or feel there is a legitimate reason to prescribe, then prescribe in small quantities without any refills until the Narcotics Division can investigate the situation. They further recommend physicians write out the quantity of the prescriptions in longhand rather than by number in order to hamper forgeries. Please call your local police department or Kentucky State Police if you have any questions.

Medicare/Medicaid Anti-Kickback Statute

Section 1128B(b) of the Social Security Act provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce business reimbursement under the Medicare or state health care programs. The offense is classified as a felony and is punishable by fines of up to \$25,000 and imprisonment for up to 5 years.

This provision is extremely broad. The types of remuneration covered specifically include kickbacks, bribes, and rebates, made directly or indirectly, in cash or in kind. In addition, prohibited conduct includes not only remuneration intended to induce referrals of patients, but remuneration intended to induce purchase, leasing, ordering, or arranging for any good, facility, service, or item paid for by Medicare or state health care programs.

Since the statute is so broad, concern has arisen that many beneficial commercial arrangements are technically covered by the statute and are, therefore, subject to criminal

prosecution. Because of this concern, Congress mandated regulations specifying those practices that will not be subject to criminal prosecution and will not provide a basis for expulsion from the Medicare and Medicaid programs (Safe Harbor Regulations).

The fact that an arrangement does not meet the standards of the Safe Harbors does not mean it is subject to criminal sanctions; it only means that the arrangement would be investigated to determine if it is a violation of the law. The regulations and business arrangements to which they apply are complicated, and every physician should consult with an attorney to advise them how to proceed. The KMA Judicial Council has directed the KMA to advise members of the AMA ethical guidelines regarding physician referrals. All members should be aware that adherence to the following guidelines does not ensure compliance with state and federal law.

Physicians need to know that although investment in facilities to which they refer patients has not been viewed to date as unethical, several important requirements must be met. Among these are: (a) disclosure and an opportunity for the patient to go elsewhere, with a specific, alternative facility identified; (b) financial return that is commensurate with the capital risk taken; (c) no tying of investment return to volume of referrals; (d) objective utilization review, and (e) as with any service provided by physicians, the measure of appropriate utilization and price is not what the market will bear, but what is reasonable and necessary given the physician's position of special trust. The Judicial Council is concerned about the effect the self-referral restrictions will have on rural physicians. Any rural physicians who are adversely affected are asked to write the Judicial Council at KMA Headquarters.

Danger of Substance Abuse During Pregnancy

KMA is supporting the efforts of the Kentucky State Legislative Task Force on Alcohol and Drug Use During Pregnancy in an effort to encourage increased access to prevention, early intervention, and treatment services for pregnant women who use harmful substances during pregnancy.

KMA has produced a quantity of small posters which are available at no charge to physicians who may wish to post them in their reception area. Call the KMA Headquarters Office — 502/426-6200.

Medicaid Formulary

At the 1991 KMA Annual Meeting, the House of Delegates adopted Resolution S, which addressed a need for improvements in the Medicaid formulary in order to provide physicians greater discretion in their treatment options.

At the request of the Technical Advisory Committee on Physician Services (Title XIX) and the Board of Trustees, KMA is seeking your input on suggestions to improve the Medicaid formulary. Please send any suggestions you have to the KMA Headquarters Office, Attention: Technical Advisory Committee on Physician Services (Title XIX).

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Boyd

Everett B. Gevedon, MD — A
1120 Beechwood Ave, Ashland 41101
1983, U of Louisville

Mary T. Legenza, MD — S
2222 Winchester Ave, Ashland 41101
1984, Medical College of Ohio

Christian

Jack R. Vaught, MD — OBG
310 Deepwood Dr, Hopkinsville 42240
1961, U of Tennessee

Daviess

Jeffrey B. Warren, MD — P
922 Triplett St #4, Owensboro 42301
1986, U of Louisville

Henderson

Pramod V. Prabhu, MD — R
1401 N Elm St, Henderson 42420
1974, Mysore Medical College, India

Jefferson

Ahmet S. Akaydin, MD — AN
2140 Long Run Rd, Louisville 40245
1986, U of Kentucky

Hal Baumann, MD — IM
117 S Indiana Ave, Sellersburg, IN 47172
1983, U of Kentucky

Sheldon J. Bond, MD — S
9003 Spruce Tree Pl, Louisville 40242
1983, Medical College of Wisconsin

E. Britt Brockman, MD — OPH
1305 Wall St #200, Jeffersonville, IN 47130
1986, U of Louisville

Karen E. Duckwall, MD — OBG
234 E Gray St #652, Louisville 40202
1978, U of Louisville

Don R. Duff, MD — IM
2600 Drayton Dr, Louisville 40205
1986, U of Louisville

Geoffrey Durham-Smith, MD — S
8600 Charing Cross Rd, Louisville 40222
1974, University of Melbourne

Michelle A. Fiorella, DO — GP
220 Breckinridge Ln, Louisville 40207
1987, Col of Osteopathic M & S, Des Moines

Christopher G. Henes, MD — C
825 Barret Ave, Louisville 40204
1980, Yale U School of Medicine

Douglas A. Kaffenberger, MD — R
6400 Dutchmans Pky, #35, Louisville 40205
1985, U of Louisville

Eleanor D. Lederer, MD — NEP
500 S Floyd, Louisville 40202
1978, Baylor Col of Medicine

Alankara N. Peiris, MD — END
6211 Two Springs Ln, Louisville 40207
1977, St. Bartholomew Hosp Med School, London

Andrew C. Renz, MD — PD
4171 Westport Rd, Louisville 40207
1988, Wright State U School of Medicine

Vickie L. Shaffer, MD — PD
4171 Westport Rd, Louisville 40207
1988, U of Louisville

Richard M. Spalding, MD — IM
117 S Indiana Ave, Sellersburg, IN 47172
1978, U of Louisville

Salvator J. Vicario, MD — EM
530 S Jackson, Louisville 40202
1976, Mt. Sinai School of Medicine

McCracken

Gershon Lundberg, MD — R
2421 Broadway, Paducah 42001
1981, U of Oregon

David C. Waggoner, MD — P
657 Lone Oak Rd #6, Paducah 42001
1969, Vanderbilt U

Nelson

Deborah B. Mattingly, MD — IM
108 N Salem Dr, Bardstown 40004
1988, U of Louisville

Northern Kentucky

Nancy Jo Borchers, MD — PD
936 Meadowland Dr, Cincinnati OH 45255
1988, U of Kentucky

Maureen M. Pelletier, MD — OBG
1 Medical Village Dr, Edgewood 41017
1984, Tufts U

Pike

Gregory V. Hazelett, DO — OTO
114 Cedar Creek Rd, Pikeville 41501
1985, West Virginia School of Osteopathic Med

Pulaski

Michael D. Thomas, MD — FP
500 Bourne Ave, Somerset 42501
1962, U of Louisville

Shelby

Eric J. Siegel, MD — PD
515 Hospital Dr, Shelbyville 40065
1988, Thomas Jefferson Medical Col

Warren

William H. Dewhurst, MD — P
1035 Porter Pike Rd, Bowling Green 42103
1954, Medical College of Virginia

Sherryl B. Reed, MD — IM
2700 N Mill Ave #164, Bowling Green 42101
1988, U of Louisville

New In-Training

Fayette

Sylvia L. Cerei, MD — PD

Jefferson

Francis Duque, MD — IM

Mary Head Groot, MD — IM

David J. Harrell, MD — S

Milton S. Jackson, MD — S

Laura R. Klein, MD — IM

Leon Lane, MD — OPH

Hector O. Laurel, MD — AN

Joseph P. Lynch, MD — IM

David R. Maxson, MD — AN

Jon M. Miller, MD — P

Christopher V. Pitcock, MD — FP

John B. Rademaker, MD — AN

Walter J. Ricci, MD — EM

Edward A. Rothschild, II, MD — AN

Shao-min Shi, MD — S

Jacqueline M. Sugarman, MD — PD

St. Elizabeth's

Thomas M. Adams, MD — FP

DEATHS**Charles B. Billington, MD
Paducah
1910-1991**

Charles B. Billington, MD, a retired internist, died December 2, 1991. Dr Billington was a 1934 graduate of the University of Tennessee College of Medicine and a life member of KMA.

**Joseph S. Faulkner, MD
Ft. Thomas
1908-1991**

Joseph S. Faulkner, MD, a retired family practitioner, died December 27, 1991. A 1932 graduate of the University of Louisville School of Medicine, Dr Faulkner was a life member of KMA.

**Eduardo S. Remo, MD
Covington
1940-1992**

Eduardo S. Remo, MD, a pediatrician, died February 3, 1992. A 1965 graduate of the University of the East, Ramon Magsaysay Memorial (Philippines), Dr Remo was an active member of KMA.

**Everett H. Sanneman, MD
Louisville
1920-1992**

Everett H. Sanneman, MD, a retired internist, died February 23, 1992. Dr Sanneman was a 1945 graduate of Washington University School of Medicine and a life member of KMA.



Medical Challenges In An Age Of Risk

KMA Annual Meeting • Sept 13-17 • Hyatt Regency
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KEMPAC Elects Officers for 1992

KEMPAC officers elected for 1992 are as follows:

Samuel J. King, MD	Chairman
Wayne W. Kotcamp, MD	Treasurer
Preston P. Nunnelley, MD	Assistant Treasurer
Jerry Martin, MD	Secretary

The members of the KEMPAC Board of Directors are your representatives and encourage you to discuss political activity in your local area with them.

The districts and directors are:

First Congressional District

Dan Miller, MD — 312 S 8th St, Murray, KY 42071
Larry Franks, MD — 216 Berger Road, Paducah, KY 42001

Second Congressional District

Salem George, MD — 1129 W Chandler, Lebanon, KY 40033
Jerry Martin, MD — 1167 31 W By-pass, Bowling Green, KY 42101

Third Congressional District

Wayne W. Kotcamp, MD — Ste 200, 601 S Floyd St, Louisville, KY 40202
William P. VonderHaar, MD — 1170 E Broadway, Ste 400, Louisville, KY 40204

Fourth Congressional District

Harry W. Carter, MD — St. Elizabeth Medical Ctr, Covington, KY 41014
Ronald L. Levine, MD — 250 E Liberty, Ste 510, Louisville, KY 40202

Fifth Congressional District

James D. Crase, MD — 340 Bogle St, Somerset, KY 42501
William D. Pratt, MD — Medical Arts Bldg, London, KY 40741

Sixth Congressional District

G. Irene Minor, MD — PO Box 4010, Berea, KY 40403
Preston P. Nunnelley, MD — 2620 Wilhite Drive, Lexington, KY 40503

Seventh Congressional District

Samuel J. King, MD — PO Box 3207, Pikeville, KY 41501
Kenneth R. Hauswald, MD — PO Box 1865, Ashland, KY 41101

Represent Auxiliary to KMA

Mrs Donald R. Neel (Faye) — 3 Stone Creek Park, Owensboro, KY 42303
Mrs Bob DeWeese (Angie) — 6206 Glenhill Road, Louisville, KY 40222
Mrs Roger Haas (Barbara) — 36 Rio Vista Drive, Ft Thomas, KY 41075
Mrs Thomas Slabaugh (Sugar) — 2160 Island Drive, Lexington, KY 40502

Exofficio Members

Donald C. Barton, MD — Doctors' Park, Corbin, KY 40701
Wally O. Montgomery, MD — PO Box 7329, Paducah, KY 42001
David B. Stevens, MD — 1900 Richmond Road, Lexington, KY 40502

_____ YES, I wish to become a KEMPAC/AMPAC member.

_____ \$100 Physician _____ \$100 Spouse _____ \$10 Resident _____ \$10 Student
Personal check enclosed _____ Charge to my credit card _____ VISA _____ Master Card

Credit Card No. _____

Expiration Date _____

Signature _____

If your practice is incorporated, KEMPAC and AMPAC voluntary political contributions should be written on a PERSONAL CHECK, not a PSC check. Contributions are not limited to the suggested amount. Neither the AMA nor the KMA will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions. A portion of voluntary political contributions will be used in connection with Federal elections and are subject to the prohibitions and limitations of the Federal Election Campaign Act. Contributions are not tax deductible.

AWARDS NOMINATIONS

The KMA Awards Committee is accepting nominations for the two highest awards the Association presents. The Distinguished Service Award is presented annually to a member of the Association based on the following criteria:

- Contributions to organized medicine (including membership in county society, attendance of county and state meetings, service on committees, leadership as an officer, etc.)
- Individual medical service
- Community health, education and civic betterment
- Medical research

The nominee may qualify on any one or all combinations of these points. Reasons for the nominations should be clearly stated.

The Kentucky Medical Association Award is presented to an outstanding lay person in Kentucky each year in honor of his or her outstanding accomplishments in the field of public health and/or medical care.

The Awards Committee will have the responsibility to choose recipients of the KMA Distinguished Service Award and the Kentucky Medical Association Award. Any county society or individual member may suggest nominees to the committee.

The awards are presented at the President's Luncheon during the annual meeting.

AWARD NOMINATION FORM

Name: _____

Address: _____

Birth Date: _____ Place: _____

Marital Status: _____

Spouse's Name: _____

Children: _____

☐ Distinguished Service Award (Physician)

☐ KMA Award (Lay Person)

Education: _____

Military: _____

Membership in Professional Organizations: _____

Membership in Civic Organizations: _____

Honors and Awards: _____

(Describe nominees qualifications and other pertinent information which the Awards Committee may consider in making its decision.)

Name of Person or Group Submitting Nomination: _____

Address: _____

Phone: (Home) _____

(Office) _____

Please fill in and mail to: KMA, Attn: Awards Committee, 301 N Hurstbourne Pky, Ste 200, Louisville, KY 40222

Deadline for receiving nominations is July 15.

RATES AND DATA

All orders for classified advertising must be placed in writing and will be subject to approval by the Editorial Board. The right is reserved to decline or withdraw advertisements at the publisher's discretion.

Deadline: First day of month prior to month of publication.

Word count: Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

Rates to KMA members: \$10 per insertion up to 50 words, 25¢ each additional word. To non-members; \$30 per insertion up to 50 words, 25¢ each additional word.

Send advance payment with order to: The Journal of KMA, 301 N Hurstbourne Pky, Ste 200, Louisville, KY 40222.

KENTUCKY — FAMILY PRACTICE RESIDENCY FACULTY POSITIONS — HAZARD, KENTUCKY.

The University of Kentucky Center for Rural Health has established an innovative 1 plus 2 family practice residency program in the Appalachian region of south eastern Kentucky. The newly developed training program is designed to prepare family practitioners for rural practice. This exciting new program is in need of faculty members who are interested in combining teaching, clinical practice (including obstetrics) and research. Candidates should be board-certified or eligible, and have a strong interest in rural family medicine. Excellent fringe benefits and competitive salaries are offered. This outstanding center is located in a scenic, mountain setting with access to numerous cultural and recreational activities. Come join us in historic Appalachia. The University of Kentucky is an affirmative action/equal opportunity employer. Applicants should send current curriculum vitae and three references to: Joseph A. Florence, MD, Director, East Kentucky Family Practice Residency Program, UK Center for Rural Health, 100 Airport Gardens Road, Suite 10, Hazard, Kentucky 41701. 606/439-3557.

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THE DEPARTMENT FOR MEDICAID SERVICES

— seeks the services of a General Prac-

titioner for Medical Consultation to provide: (1) judgement for matters regarding physician billing to the Kentucky Medical Assistance Program; and (2) other activities requiring medical expertise. To request a Request for Proposal, please send written request to: Department for Medicaid Services, Attention: Janet Moore, CHR Building, 3rd Floor East, 275 E Main St, Frankfort, KY 40621. *All requests for Requests for Proposal must be received by April 20, 1992.*

INDIANA — A successful family medicine practice seeks a BE/BC family physician in a picturesque community 45 minutes southeast of Indianapolis. The affiliated 325-bed hospital is offering attractive, competitive financial package options. OB optional. Exceptional opportunity for a balanced professional and personal lifestyle. For further information, send CV to: Andrew Johns, Physician Services of America, Suite 250, 2000 Warrington Way, Louisville, KY 40222, or Call 1/800/626-1857, ext 237.

TELERADIOLOGY UNIT FOR SALE — Data-span unit used one year to transmit X-rays over telephone lines. High quality image transmission. \$5000 negotiable. Pediatric Radiology Associates, PO Box 35070, Louisville, KY 40232, 502/629-7661.

FOR SALE — An 1849A Real-Time Ultrasound Scanner with Ferno Cart for 1849, Keyboard with Mod, Sony Video Graphics Printer, and Bi-Planer Probe. PRICE: \$18,995.00. For additional information, please contact Suvas G. Desai, MD at 606/623-0202 between the hours of 8:00 am to 5:00 pm. After these hours please call 606/266-3625.

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BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- or 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdose. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully

monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

4/11/91 • P91CA6277V

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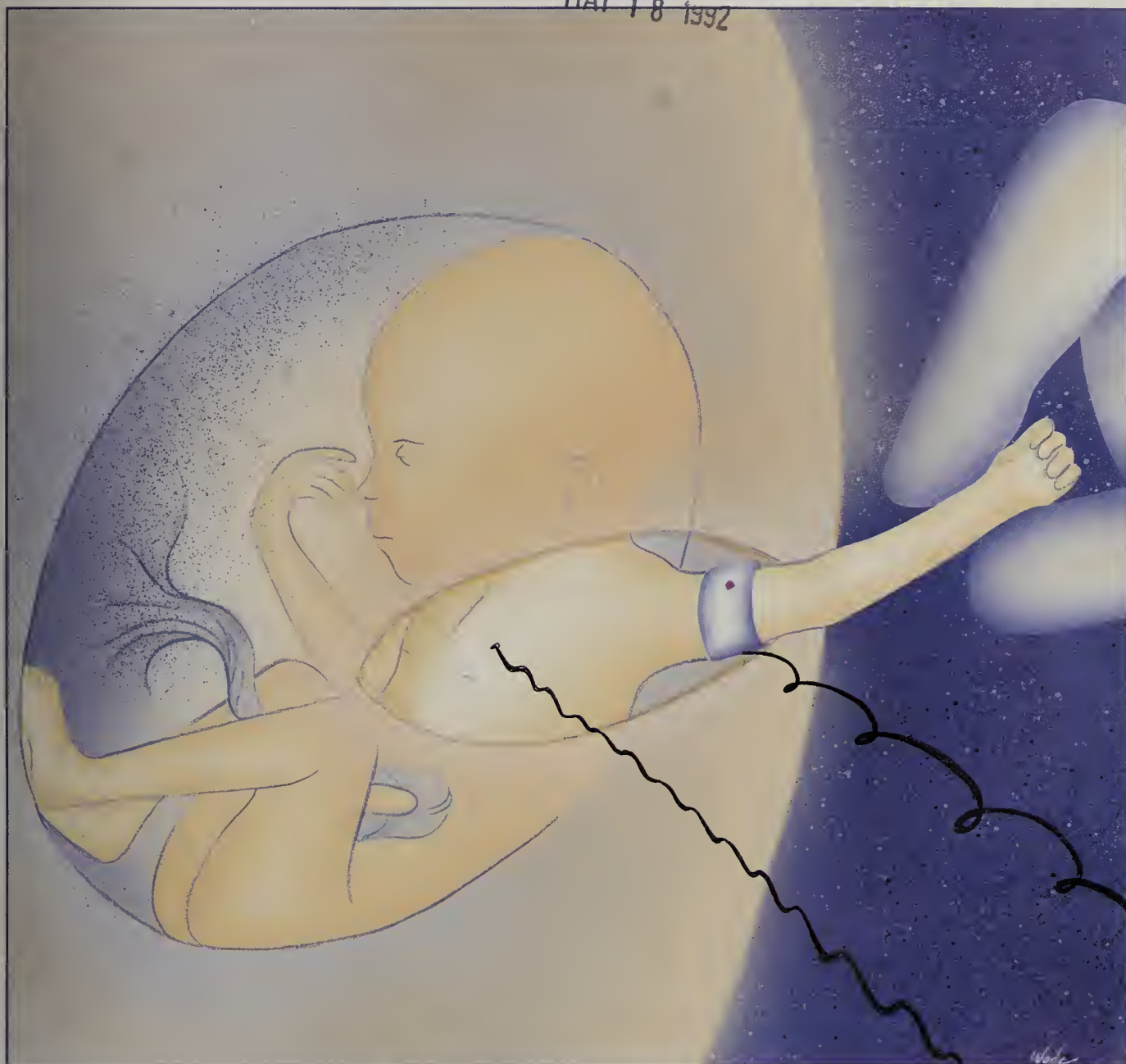
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Parke-Davis is confident that for many of your hypertensive patients ACCUPRIL will achieve the decrease in blood pressure you expect.

If, in your medical judgment, your patient requires a diuretic in addition to ACCUPRIL at any time during ACCUPRIL therapy, Parke-Davis will refund your patient's cost of the diuretic.*†



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ONCE-A-DAY ‡
ACCUPRIL®
quinapril HCl tablets 10, 20, 40 mg

* See DOSAGE AND ADMINISTRATION section of prescribing information.

† If, after an adequate trial of ACCUPRIL alone, based on your medical judgment as the prescribing physician, you determine that your patient requires the addition of a diuretic, Parke-Davis will refund to the patient his/her cost for the diuretic prescription less any amount reimbursed or paid for by an HMO, insurance company, or any other plan or program.

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‡ In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.

ACCUPRIL is available in 10, 20, and 40 mg tablets. Usual initial starting dosage is 10 mg once daily.

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Please see brief summary of prescribing information on following page.

Accupril® (Quinapril Hydrochloride Tablets)

Before prescribing, please see full prescribing information. A brief summary follows.

INDICATIONS AND USAGE

ACCUPRIL is indicated for the treatment of hypertension. It may be used alone or in combination with thiazide diuretics. In using ACCUPRIL, consideration should be given to the fact that another angiotensin-converting enzyme (ACE) inhibitor, captopril, has caused agranulocytosis, particularly in patients with renal impairment or collagen vascular disease. Available data are insufficient to show that ACCUPRIL does not have a similar risk (see WARNINGS).

CONTRAINDICATIONS

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

WARNINGS

Angioedema: Angioedema of the face, extremities, lips, tongue, glottis, and larynx has been reported in patients treated with ACE inhibitors and has been seen in 0.1% of patients receiving ACCUPRIL. Angioedema associated with laryngeal edema can be fatal. If laryngeal stridor or angioedema of the face, tongue, or glottis occurs, treatment with ACCUPRIL should be discontinued immediately, the patient treated in accordance with accepted medical care, and carefully observed until the swelling disappears. In instances where swelling is confined to the face and lips, the condition generally resolves without treatment; antihistamines may be useful in relieving symptoms.

Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, emergency therapy including, but not limited to, subcutaneous epinephrine solution 1:1000 (0.3 to 0.5 mL) should be promptly administered (see ADVERSE REACTIONS).

Hypotension: Symptomatic hypotension was rarely seen in uncomplicated hypertensive patients treated with ACCUPRIL but, as with other ACE inhibitors, it is a possible consequence of therapy in salt/volume depleted patients, such as those previously treated with diuretics or dietary salt restriction or who are on dialysis (see PRECAUTIONS, DRUG INTERACTIONS, and ADVERSE REACTIONS). In controlled studies, syncope was observed in 0.4% of patients (N = 3203); this incidence was similar to that observed for captopril (1%) and enalapril (0.8%).

In patients with concomitant congestive heart failure, with or without associated renal insufficiency, ACE inhibitor therapy may cause excessive hypotension, which may be associated with oliguria or azotemia and, rarely, with acute renal failure and death. In such patients, ACCUPRIL therapy should be started at the recommended dose under close medical supervision. These patients should be followed closely for the first 2 weeks of treatment and whenever the dosage of antihypertensive medication is increased (see DOSAGE AND ADMINISTRATION).

If symptomatic hypotension occurs, the patient should be placed in the supine position and, if necessary, normal saline may be administered intravenously. A transient hypotensive response is not a contraindication to further doses; however, lower doses of ACCUPRIL or reduced concomitant diuretic therapy should be considered.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression rarely in patients with uncomplicated hypertension, but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease such as systemic lupus erythematosus or scleroderma. Agranulocytosis did occur during ACCUPRIL treatment in one patient with a history of neutropenia during previous captopril therapy. Available data from clinical trials of ACCUPRIL are insufficient to show that, in patients without prior reactions to other ACE inhibitors, ACCUPRIL does not cause agranulocytosis at similar rates. As with other ACE inhibitors, periodic monitoring of white blood cell counts in patients with collagen vascular disease and/or renal disease should be considered.

Fetal/Neonatal morbidity and mortality: ACE inhibitors, including ACCUPRIL, can cause fetal and neonatal morbidity and mortality when administered to pregnant women.

When ACE inhibitors have been used during the second and third trimesters of pregnancy, there have been reports of hypotension, renal failure, skull hypoplasia, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios has been associated with fetal limb contractures, craniofacial deformities, hypoplastic lung development, and intrauterine growth retardation.

Prematurity and patent ductus arteriosus have been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure or to the mother's underlying disease. It is not known whether exposure limited to the first trimester can adversely affect fetal outcome.

A patient who becomes pregnant while taking ACE inhibitors, or who takes ACE inhibitors when already pregnant, should be apprised of the potential hazard to her fetus. If she continues to receive ACE inhibitors during the second or third trimester of pregnancy, frequent ultrasound examinations should be performed to look for oligohydramnios. When oligohydramnios is found, ACE inhibitors should generally be discontinued.

Infants with histories of in utero exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Hemodialysis and peritoneal dialysis have little effect on the elimination of quinapril and quinaprilat.

No fetotoxic or teratogenic effects were observed in rats at quinapril doses as high as 300 mg/kg/day (180 and 30 times the maximum daily human dose when based on mg/kg and mg/m², respectively), despite maternal toxicity at 150 mg/kg/day. Tested later in gestation and during lactation, reduced offspring body weight was seen at ≥25 mg/kg/day, and changes in renal histology (juxtaglomerular cell hypertrophy, tubular/pelvic dilation, glomerulosclerosis) were observed both in dams and offspring treated with 150 mg/kg/day. Quinapril was not teratogenic in the rabbit; however, as noted with other ACE inhibitors, maternal toxicity and embryotoxicity were seen in some rabbits at quinapril doses as low as 0.5 mg/kg/day (one time the recommended human dose) and 1.0 mg/kg/day, respectively.

PRECAUTIONS

General

Impaired renal function: As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including ACCUPRIL, may be associated with oliguria and/or progressive azotemia and rarely acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine have been observed in some patients following ACE inhibitor therapy. These increases were almost always reversible upon discontinuation of the ACE inhibitor and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some hypertensive patients with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when ACCUPRIL has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of any diuretic and/or ACCUPRIL may be required.

Evaluation of hypertensive patients should always include assessment of renal function (see DOSAGE AND ADMINISTRATION).

Hyperkalemia and potassium-sparing diuretics: In clinical trials, hyperkalemia (serum potassium ≥5.8 mmol/L) occurred in approximately 2% of patients receiving ACCUPRIL. In most cases, elevated serum potassium levels were isolated values which resolved despite continued therapy. Less than 0.1% of patients discontinued therapy due to hyperkalemia. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with ACCUPRIL (see PRECAUTIONS, DRUG INTERACTIONS).

Surgery/anesthesia: In patients undergoing major surgery or under anesthesia with agents that produce hypotension, ACCUPRIL will block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients

Angioedema: Angioedema, including laryngeal edema, can occur with treatment with ACE inhibitors, especially following the first dose. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to stop taking the drug until they have consulted with their physician (see WARNINGS).

Symptomatic hypotension: Patients should be cautioned that lightheadedness can occur, especially during the first few days of ACCUPRIL therapy, and that it should be reported to a physician. If actual syncope occurs, patients should be told to not take the drug until they have consulted with their physician (see WARNINGS).

All patients should be cautioned that inadequate fluid intake or excessive perspiration, diarrhea, or vomiting can lead to an excessive fall in blood pressure because of reduction in fluid volume, with the same consequences of lightheadedness and possible syncope.

Patients planning to undergo any surgery and/or anesthesia should be told to inform their physician that they are taking an ACE inhibitor.

Hyperkalemia: Patients should be told not to use potassium supplements or salt substitutes containing potassium without consulting their physician (see PRECAUTIONS).

Accupril® (Quinapril Hydrochloride Tablets)

Neutropenia: Patients should be told to report promptly any indication of infection (eg, sore throat, fever) which could be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with ACCUPRIL is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions

Concomitant diuretic therapy: As with other ACE inhibitors, patients on diuretics, especially those on recently instituted diuretic therapy, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with ACCUPRIL. The possibility of hypotensive effects with ACCUPRIL may be minimized by either discontinuing the diuretic or cautiously increasing salt intake prior to initiation of treatment with ACCUPRIL. If it is not possible to discontinue the diuretic, the starting dose of quinapril should be reduced (see DOSAGE AND ADMINISTRATION).

Agents increasing serum potassium: Quinapril can attenuate potassium loss caused by thiazide diuretics and increase serum potassium when used alone. If concomitant therapy of ACCUPRIL with potassium-sparing diuretics (eg, spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes is indicated, they should be used with caution along with appropriate monitoring of serum potassium (see PRECAUTIONS).

Tetracycline and other drugs that interact with magnesium: Simultaneous administration of tetracycline with ACCUPRIL reduced the absorption of tetracycline by approximately 28% to 37%, possibly due to the high magnesium content in ACCUPRIL tablets. This interaction should be considered if coprescribing ACCUPRIL and tetracycline or other drugs that interact with magnesium.

Lithium: Increased serum lithium levels and symptoms of lithium toxicity have been reported in patients receiving concomitant lithium and ACE inhibitor therapy. These drugs should be co-administered with caution, and frequent monitoring of serum lithium levels is recommended. If a diuretic is also used, it may increase the risk of lithium toxicity.

Other agents: Drug interaction studies of ACCUPRIL with other agents showed:

- Multiple dose therapy with propranolol or cimetidine has no effect on the pharmacokinetics of single doses of ACCUPRIL.
- The anticoagulant effect of a single dose of warfarin (measured by prothrombin time) was not significantly changed by quinapril coadministration twice-daily.
- ACCUPRIL treatment did not affect the pharmacokinetics of digoxin.
- No pharmacokinetic interaction was observed when single doses of ACCUPRIL and hydrochlorothiazide were administered concomitantly.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Quinapril hydrochloride was not carcinogenic in mice or rats when given in doses up to 75 or 100 mg/kg/day (50 to 60 times the maximum human daily dose, respectively, on a mg/kg basis and 3.8 to 10 times the maximum human daily dose when based on a mg/m² basis) for 104 weeks. Female rats given the highest dose level had an increased incidence of mesenteric lymph node hemangiomas and skin/subcutaneous lipomas. Neither quinapril nor quinaprilat were mutagenic in the Ames bacterial assay with or without metabolic activation. Quinapril was also negative in the following genetic toxicology studies: *in vitro* mammalian cell point mutation, sister chromatid exchange in cultured mammalian cells, micronucleus test with mice, *in vitro* chromosome aberration with V79 cultured lung cells, and in an *in vivo* cytogenetic study with rat bone marrow. There were no adverse effects on fertility or reproduction in rats at doses up to 100 mg/kg/day (60 and 10 times the maximum daily human dose when based on mg/kg and mg/m², respectively).

Pregnancy

Pregnancy Category D: See WARNINGS, Fetal/Neonatal morbidity and mortality.

Nursing Mothers

It is not known if quinapril or its metabolites are secreted in human milk. Quinapril is secreted to a limited extent, however, in milk of lactating rats (5% or less of the plasma drug concentration was found in rat milk). Because many drugs are secreted in human milk, caution should be exercised when ACCUPRIL is given to a nursing mother.

Geriatric Use

Elderly patients exhibited increased area under the plasma concentration time curve (AUC) and peak levels for quinaprilat compared to values observed in younger patients; this appeared to relate to decreased renal function rather than to age itself. In controlled and uncontrolled studies of ACCUPRIL where 918 (21%) patients were 65 years and older, no overall differences in effectiveness or safety were observed between older and younger patients. However, greater sensitivity of some older individual patients cannot be ruled out.

Pediatric Use

The safety and effectiveness of ACCUPRIL in children have not been established.

ADVERSE REACTIONS

ACCUPRIL has been evaluated for safety in 4960 subjects and patients. Of these, 3203 patients, including 655 elderly patients, participated in controlled clinical trials. ACCUPRIL has been evaluated for long-term safety in over 1400 patients treated for 1 year or more.

Adverse experiences were usually mild and transient.

Discontinuation of therapy because of adverse events was required in 4.7% of patients treated with ACCUPRIL in placebo-controlled hypertension trials.

Adverse experiences probably or possibly related to therapy or of unknown relationship to therapy occurring in 1% or more of the 1563 patients in placebo-controlled hypertension trials who were treated with ACCUPRIL are shown below.

Adverse Events in Placebo-Controlled Trials

	ACCUPRIL (N = 1563) Incidence (Discontinuation)	Placebo (N = 579) Incidence (Discontinuation)
Headache	5.6 (0.7)	10.9 (0.7)
Dizziness	3.9 (0.8)	2.6 (0.2)
Fatigue	2.6 (0.3)	1.0
Coughing	2.0 (0.5)	0.0
Nausea/Vomiting	1.4 (0.3)	1.9 (0.2)
Abdominal Pain	1.0 (0.2)	0.7

Clinical adverse experiences probably or possibly related, or of uncertain relationship to therapy, occurring in 0.5% to 1.0% (except as noted) of the patients treated with ACCUPRIL (with or without concomitant diuretic) in controlled or uncontrolled trials (N = 4397) and less frequent, clinically significant events seen in clinical trials or post-marketing experience (the rarer events are in italics) include (listed by body system):

General: back pain, malaise

Cardiovascular: palpitation, vasodilation, tachycardia, heart failure, hyperkalemia, myocardial infarction, cerebrovascular accident, hypertensive crisis, angina pectoris, orthostatic hypotension, cardiac rhythm disturbances

Gastrointestinal: dry mouth or throat, constipation, gastrointestinal hemorrhage, pancreatitis, abnormal liver function tests

Nervous/Psychiatric: somnolence, vertigo, syncope, nervousness, depression

Integumentary: increased sweating, pruritus, exfoliative dermatitis, photosensitivity reaction

Urogenital: acute renal failure

Other: amblyopia, pharyngitis, sinusitis, bronchitis, agranulocytosis, thrombocytopenia

Angioedema: angioedema has been reported in patients receiving ACCUPRIL (0.1%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with ACCUPRIL should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Clinical Laboratory Test Findings

Hematology: (See WARNINGS)

Hyperkalemia: (See PRECAUTIONS)

Creatinine and blood urea nitrogen: Increases (>1.25 times the upper limit of normal) in serum creatinine and blood urea nitrogen were observed in 2% and 2%, respectively, of patients treated with ACCUPRIL alone. Increases are more likely to occur in patients receiving concomitant diuretic therapy than in those on ACCUPRIL alone. These increases often remit on continued therapy.

* In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.



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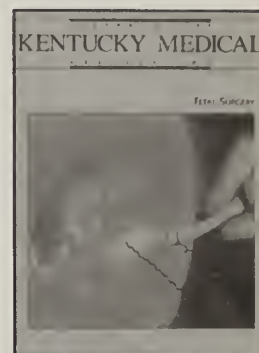
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Our Image Needs Polishing

Health care has become the second most popular topic of discussion amongst Americans. Only the economy and its lack of improvement is of greater interest to most people. The economy is likely to make a recovery this year and then health care will be the dominant topic at the state and national level. The public is focusing on two health care issues — the affordability of adequate health insurance and the accessibility of adequate health care for all Americans.

Though many physicians have long forsaken the notion that doctors have control of health care policy, the public still holds physicians accountable for our health care system. The public expects physicians to assume a leadership position in solving health care issues. The public also believes that physicians are a major cause of the problem of affectability and accessibility of health care. There is little solace in knowing that physicians' services account for only 19% of the total dollars spent on health care. That percentage has not changed in 25 years.

"Though many physicians have long forsaken the notion that doctors have control of health care policy, the public still holds physicians accountable for our health care system."

The people want a better image of physicians. They want to believe that physicians have the best interest of their patients at heart when physician leaders espouse solutions to health care problems.

However, our external image often obscures our patient advocacy positions. It is not easy for our patients to look beyond the trappings of upper income living that many physicians enjoy when the public is concerned about the affordability of health care insurance. They wonder why doctors are so disgruntled when

a politician or business leader suggests that physician reimbursement needs to be adjusted downward. This is especially troubling in these hard economic times when many are without jobs, and many more are seeing their employment benefits curtailed. The public is slightly suspicious of physician motives of patient advocacy when we physician leaders spend so much time battling for physician rights on economic issues. Can we really explain why our professional services cost so much?

Should we be surprised that the physician-patient bond is being assailed, when many of us now work in groups where the patient frequently sees a different doctor each time he has a health care crisis? Why should we expect patients to understand the rationale for group practice if we don't explain it to them? And if there is little or no bonding between the physician and patient, why should we expect patients to look for and accept physician solutions to health care issues?

We physicians are constantly reminding the public that medical

technology is advancing at break-neck speed and the cost of these advances is greatly contributing to the rising cost of health care. Why does it surprise us that the public would like to be reassured that our continuing medical education is keeping up with these technologic advances? Is mandatory continuing education really that unreasonable? Why don't we explain to our patients what efforts we are making to provide state-of-the-art medicine? Are we too busy to explain our training?

"Our external image often obscures our patient advocacy positions."

The public wants access to health care. Many people in the inner city and rural areas don't expect the professor from the medical school to take care of them. But why can't they have a nurse practitioner or physician assistant see them and treat them for their routine health problems? Why are physicians opposed to increasing the scope of practice of limited licensed practitioners?

How do we expect the public to understand that the Board of Medical Licensure is the best organization to uphold the professional standards of physicians and guard the public against unscrupulous or incompetent medical practice? Isn't that like the fox guarding the hen house?

I believe that we can explain our position on these and many other thorny issues. We can also reexamine our positions and adjust those positions that are hindering our ability

to be advocates of patient care and well being.

The KMA physician leadership is willing to address each and every issue. We are willing to espouse sound principles that will advocate affordable and accessible, good health care. But we cannot individually or collectively change the public's image of doctors. That responsibility rests with each and every doctor in the Commonwealth. We can advocate professionalism in medical practice, but the public will only recognize physicians' professionalism when they come into contact with their local physician and he or she exemplifies it. We can advocate reasonable pricing for health services, but the public will only recognize it when physicians can honestly talk to patients about why the service has the agreed upon value.

The public will not begrudge physicians a good income and a lifestyle that reflects that income if they recognize sincere, stressful physician effort and long hours of work. However, it will be easier to accept if we physicians do not flaunt our financial well being. The KMA physician leadership cannot change the public's image, but we can bring to your attention this perceived dichotomy, and you can demonstrate the medical professionalism that dictates each of your patients has a right to your best care regardless of their ability to pay. You can show your desire to make health care affordable by having your services reasonably priced. You can demonstrate medicine's concern for universal access to health care by participating in whatever way possible at the local level in efforts to treat those who cannot afford to purchase necessary health services.

You can demonstrate physicians' interest in striving for excellence in

patient care by constantly updating your professional knowledge and skills. Your peers and your patients will rapidly become aware of your professional competence and thirst for improvement. The physician's image will be improved.

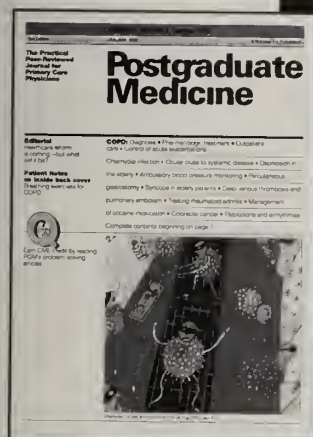
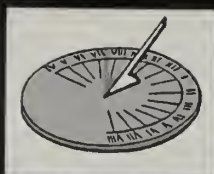
You can improve the public's image of physicians by making certain that you refer each patient to another physician or health facility based solely on the patient's need, the physician's competency, and the facility's ability to perform the service in a high quality, cost effective manner. You can improve our image if you discuss with patients why and when your best efforts are sometimes compromised by the type of health insurance that they purchased.

The health care crisis is rapidly approaching. The KMA leadership looks forward to representing the physician membership in the development and implementation of solutions to the patient care issues. We will continue to be patient advocates. As you are all aware, a special session of the state legislature will almost certainly be called by the Governor to address the issues elucidated by the health care task force.

It will be my pleasure to serve as President of the KMA in September 1992. I look forward to the challenge of improving health care in the Commonwealth. I will work tirelessly for you, but neither I nor all the physician leadership of the KMA put together can improve the public's image of physicians. Each of us can improve that image each day by striving to attain the degree of professionalism that allows us to deliver high quality, affordable care to everyone that needs it.

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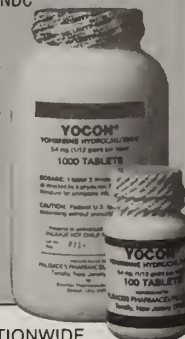
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

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Care of the Pregnant Asthmatic

Karen R. Habenstein, MD; Elizabeth D. Loy, MD;
J.M. Mendieta, MD; Miguel A. Ossorio, MD

Treatment of asthma in the pregnant female poses a dilemma for the physician who must select medications that will effectively suppress maternal bronchospasm but that will not jeopardize the fetus. To compound the practitioner's problem, the inability to perform human studies with asthma drugs has led the pharmaceutical companies to formally list precautions against the use of antiasthmatic drugs during pregnancy¹ in the Physician's Desk Reference (PDR), a book which is available to the lay public and is often introduced in medico-legal suits as the primary reference for standard of care.

This article provides the clinician with the current recommended treatments that are considered acceptable during pregnancy based on the published evidence involving animal studies and the cumulative human experience that is reported in the English language medical literature.

Introduction

Asthma complicates 1% of pregnancies and may be associated with maternal and fetal morbidity and mortality.² An episode of status asthmaticus can be anticipated in 15% of pregnant asthmatic patients.³ Adverse outcomes are usually the result of poorly controlled bronchospasm that results in maternal hypoxemia and hyperventilation.

Suboptimal control of asthma during pregnancy may increase the incidence of multiple births, congenital malformations, low infant Apgar scores, and stillbirths.⁴ Prematurity (<37 weeks gestation), low birth weight (<2500 gms) and higher perinatal mortality rates have been documented.⁵ Other reported adverse effects include increased incidence of hyperemesis, hemorrhage, toxemia, and complicated labor.⁶

With so much at stake, it is surprising that many young female asthmatics believe that they should strive to avoid their maintenance medications. It is our suspicion that the safety and neces-

sity of asthma therapy during pregnancy is not fully appreciated by all clinicians providing prenatal counseling.

Case Report

The patient, a 23-year-old pregnant female, was admitted to the hospital from the emergency department after presenting in premature labor. Her gestational stage was estimated at 35 weeks. A pulmonary consultation was requested because her premature labor was accompanied by significant bronchospasm that was not relieved by the oral administration of terbutaline which had been administered to retard premature delivery of her infant. It was determined that the patient was an asthmatic who normally required the daily ingestion of 500 mg of a long-acting theophylline preparation and the prn use of a metaproterenol inhaler to control her symptoms. She had been admitted to the hospital on two prior occasions for bronchospasm that required intravenous theophylline and corticosteroids.

She had stopped taking her asthma medication when she learned that she was pregnant, because of her concern for her infant's safety. This was her fifth pregnancy. Her fourth pregnancy had terminated by spontaneous abortion during the first trimester. She had received monthly prenatal care since the first trimester. She stated that her physician had agreed that she could stop her asthma therapy, although her wheezing had never totally abated during the pregnancy. She had not been restarted on bronchodilators despite an emergency room visit for bronchitis 2 weeks earlier. She was started, however, on erythromycin for her chest complaints.

At the time of her examination, the fetal heart tones were stable and she was having uterine contractions every 3 minutes. Her cervix was 50% effaced and 2 cm dilated. She was dyspneic and tachypneic with a respiratory rate of 18 to 20 breaths per minute. Her vital signs were otherwise unremarkable. Bilateral expiratory wheezing was present. Deep inspiration caused the patient to

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cough nonproductively. The remainder of the examination was normal.

In addition to the oral terbutaline of 5 mg every 6 hours, intravenous theophylline was administered to reach and maintain a level of 14 mcg/dl. Corticosteroids were administered intravenously at a dose of 60 mg every 6 hours for the first 24 hours. Inhaled beta agonists were encouraged to document that the patient could correctly use this delivery device. Her wheezing was controlled and her peak expiratory flow improved from 120 LPM to greater than 300 LPM.

Her premature labor was controlled with the terbutaline and sedation. She was discharged on the third hospital day with the oral beta agonist, oral theophylline and a tapering oral corticosteroid regimen. She gave birth to a normal term infant 1 month later.

Discussion

The effect of pregnancy on asthma is variable and not fully explained. The effects of increased levels of circulating hormones, especially progesterone which is a respiratory stimulant, are thought to account for the fact that most pregnant patients complain of dyspnea. The compressive effects of an expanding uterus result in compression of the inferior vena cava, alteration of preload and venous return to the heart, and elevation of both diaphragms. These mechanical changes affect some pulmonary volume measurements, but do not alter the parameters of airflow.

Examination of nine retrospective studies involving 1,059 pregnant asthmatic patients from 1953 to 1976 found that 49% of women experienced no change in asthma symptoms, 29% of women improved and 22% of the patients had worsening of symptoms.⁷ A prospective study of 366 pregnancies confirmed that asthma symptoms will remain unchanged in one-third of patients during pregnancy, improve in one-third of patients and worsen in one-third of patients.^{8,9} With successive pregnancies, a significant concordance is observed. The predictive value of this observation is not absolute and a small number of patients may respond differently during subsequent pregnancies.

The observation that the patient's asthmatic status consistently reverts to its prepregnancy course in the postpartum period argues in favor of a modulating influence of pregnancy on lung smooth muscle.⁹

Gestational age is identified as a factor that influences the expression of asthma. In women

whose asthma improves, the symptoms abate as pregnancy progresses.¹⁰ In those asthmatics whose symptoms worsen, the increase in bronchospasm appears to occur most often in the second trimester,⁸ between the 29th and 36th weeks of gestation. Bronchospasm is noted to improve during the last 4 weeks of pregnancy, regardless of the patient's prior course. Therefore, exacerbations surrounding labor and delivery are rare in the well supervised pregnant asthmatic patient.⁸

The mechanism of the gestational modulation of asthma symptoms remains speculative. Increasing levels of circulating progesterone and estrogen may account for the gradual improvement in asthma as pregnancy progresses.¹¹ Serum progesterone has a direct relaxant effect on smooth muscle, while estrogen potentiates beta-receptor stimulation in animals.¹²

Other nonhormonal factors also contribute to the improvement of asthma during pregnancy. Circulating levels of prostaglandins with bronchodilatory effects have been shown to increase during pregnancy.¹² The improvement in bronchospasm during the last 4 weeks of pregnancy and during labor and delivery are associated with an increase in prostaglandin E. Elevations in plasma epinephrine and cortisol during labor and delivery may also limit the number of asthma attacks during this otherwise stressful event.^{13,14} Finally, the descent of the fetus during the final weeks of pregnancy may decrease the mechanical stress of the gravid uterus on the diaphragms and permit an improved ventilation perfusion match up.¹⁵

The evaluation and treatment of the pregnant asthmatic is similar to that of the nonpregnant asthmatic patient. The same physical signs and symptoms are used to assess the severity of an asthmatic attack and in monitoring the course of therapy.

None of the drugs currently used in the treatment of asthma have been extensively studied in human pregnancy.¹ Therefore, it is prudent to treat the patient with the fewest effective medications sufficient to avoid bronchospasm. The choice of medications depends on the frequency and severity of symptoms (Table 1). The most important goal is to control bronchospasm as quickly as possible, while minimizing the potential of systemic effects.

Basic preventive measures can often decrease the incidence of asthma attacks. These factors include avoidance of known triggering agents and cessation of smoking. Molds, animal danders, vigorous exercise, strong odors, and per-

fumes can cause an allergy attack with bronchospasm. While it is considered safe to undergo allergy testing during pregnancy, it is fruitless to begin immunotherapy at this stage since treatment will take at least 12 months before improvement is witnessed. Patients who have been receiving immunotherapy may continue with this treatment during pregnancy.¹

Inhaled beta-agonists are the first line treatment agents in asthma because of their efficacy and minimal side effects. Their safety profile in pregnant asthmatics has been prospectively documented.¹⁶ Although there appeared to be an increased incidence of pregnancy-induced hypertension among users of inhaled beta-agonists, this factor disappeared when the data was analyzed by multivariate regression analysis controlling for age, parity, cigarette smoking, asthma severity, and concurrent medications.

Presently no data exists regarding the safety of oral B-agonists during pregnancy. The increased risk of side effects with oral agents and the lack of data showing an advantage of oral administration over properly used inhaled B-agonists would make it prudent for physicians to avoid prescribing these agents during pregnancy unless refractory asthma is present.

Sustained hypotension has been reported as an unusual complication of the subcutaneous administration of terbutaline to a pregnant asthmatic patient. Because these patients are frequently dehydrated, the lowering of systemic vascular resistance by terbutaline's effect on the beta-2 receptors of the vascular smooth muscle may have precipitated the hypotension. The patient responded to fluid administration, supporting this speculation. This is the only documented adverse report of subcutaneous terbutaline.¹⁷

The subcutaneous use of epinephrine in pregnancy remains controversial. Although reported to decrease uteroplacental blood flow,¹⁸ investigators still advocate its use as a first line therapy in status asthmaticus³ since the risk of fetal harm from hypoxemia and hyperventilation exceeds any observed risk of epinephrine administration. It should also be recognized that epinephrine is available without prescription (Primatene) and may be used for self-medication prior to the entry into the health care system.

In patients not adequately controlled by inhaled B-agonists, the addition of theophylline is beneficial, even though its routine use in chronic asthma is undergoing renewed scrutiny. There have been no reports of increased congenital malformation or stillbirth with theophylline

Table 1. Asthma Medications in Pregnancy

Considered Safe	Severe Asthma Only	Avoid
Theophylline*	Sub-Q Epinephrine	Tetracycline
Ephedrine	Sub-Q Terbutaline	Atarax
Cromolyn sodium	IV Aminophylline	Dimetapp
Beclomethasone MDI	IV Hydrocortisone	Organidin
Methylprednisolone*	Ipratropium MDI*	SSKI
Prednisone*		
Inhaled B-agonists*		Marax (contains Atarax)
Ampicillin		Aspirin
Erythromycin		Nonsteroidal
		Anti-inflammatory
		Agents
		Inderal
		Minor tranquilizers

*secreted in breast milk in minute quantity

use.^{16,19} The clinician must be aware that theophylline kinetics change during the last half of pregnancy due to decreased clearance. Theophylline levels must be carefully monitored to maintain therapeutic values.²⁰

Corticosteroid therapy reduces relapse rates in patients with asthma and may be necessary in the management of refractory pregnant patients. Although early animal studies suggested an increased risk of cleft palate if steroids were used early in pregnancy, this phenomenon has not been observed in humans.²¹ In studies of inhaled beclomethasone or oral prednisone the incidence of fetal congenital malformations in 171 pregnancies was not increased. There appeared to be a slight trend toward low birth weight infants. Reanalysis of the data, controlling for those patients who required emergency treatment, indicated that the low birth weight infants and preterm deliveries occurred primarily in women with status asthmaticus. In essence, the complications are a consequence of refractory asthma rather than the medications used to treat the episode.²²

Inhaled steroids are preferable to oral steroids because they minimize the risk of systemic side effects. Avoiding status asthmaticus remains the primary goal, however, and oral steroids should not be withheld when objective parameters indicate their use is appropriate. Both prednisone and prednisolone slowly cross the placental barrier²² and are the agents of choice to minimize the chance of influencing fetal adrenal activity. When possible, alternate day therapy is preferred.

Cromolyn sodium is not associated with any untoward effects during human pregnancy. It is often effective in reducing asthma relapses and

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decreasing the required amount of oral corticosteroids. Presently, there is no data available on the transfer kinetics of cromolyn across the human placenta. Because it is poorly absorbed systemically after inhalation, the amount available for systemic absorption and placental transfer should be insignificant.²¹

In 15% to 20% of pregnant asthmatics, an asthma attack may be severe enough to require hospitalization.² In these patients who progress to status asthmaticus despite maximal therapy, intubation and mechanical ventilation may be lifesaving. Asthma that worsens after pregnancy often improves after delivery of the fetus. Several cases have been reported using elective termination of the pregnancy to save the mother's life. Repeated bronchoalveolar lavage of mucus plugs has been suggested anecdotally as a means of avoiding an elective therapeutic abortion based on its successful use in the late phase of a pregnant mother requiring mechanical ventilation who failed all other therapy. Frequent irrigation with a warmed metaproterenol with saline solution followed by gentle suctioning has also been advocated as a therapeutic adjunct in this emergent setting to avoid termination of pregnancy.³

The use of B-agonist, especially the oral preparations, should be avoided immediately before labor since they may relax the uterine muscle and unduly prolong labor. A patient who has required steroids before delivery will, of course, require a short term increase in supplemental steroids to offset the depression of the hypothalamic-pituitary-adrenal axis during the stress of delivery. Attention must also be paid to the theoretical risk of adrenal suppression of the fetus, which is seldom actually present.²²

In summary, recent studies support the concept that there should not be an increase in health risks for the infant and the asthmatic mother if proper medical attention is provided during the pre and postnatal periods. This is best achieved when the health personnel monitoring the asthma and those monitoring the pregnancy have an open channel of communication with the common goal of preventing episodes of bronchospasm. The use of a Peak Flow Meter (PEFR) is a sensible way to monitor day-to-day fluctuations in asthma during pregnancy.

A drugless pregnancy is often not possible or advisable in the pregnant asthmatic. If episodes of significant asthma can be avoided, the maternal-fetal outcome approaches that of the nonasthmatic pregnant population.^{11, 23} We hope that our

summary of the available literature will be of benefit to those practitioners confronting acute or chronic asthma in pregnancy.

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Immediate Breast Reconstruction at the Time of Mastectomy for Breast Cancer

Richard C. Sadove, MD; Eileen R. Scherl, MD

Immediate breast reconstruction avoids or lessens the psychosocial trauma associated with a disfiguring mastectomy. The complications seen in this small patient sample are not in excess of those seen in patients undergoing delayed reconstruction. Fifteen immediate breast reconstructions were performed at the time of mastectomy for cancer. Flap or implant reconstruction alone was determined on an individual basis. No delays in the initiation of adjuvant chemotherapy or hormone therapy were caused by the reconstructions. There were no instances of total flap loss or wound infection. One implant was lost due to exposure. Other complications were similar to those associated with modified radical mastectomy alone. These preliminary results suggest that immediate breast reconstruction at the time of mastectomy may be offered with safety to newly diagnosed breast cancer patients.

Reconstruction of the breast may lessen the emotional trauma often associated with mastectomy.¹¹ Immediate reconstruction may be a superior approach for the emotional well-being of many patients.¹²

Despite major surgical advances in breast reconstruction and the emotional benefits of such a procedure, only a minority of mastectomy patients undergo reconstruction. Many general surgeons are still reluctant to refer patients for immediate or delayed reconstruction. Unsubstantiated concerns exist regarding the compromise of cure by interference with detection or treatment of a local recurrence, the cost, and the overall aesthetic results.⁶ In addition, there have been concerns regarding adequacy of the cancer operation, delay of adjuvant irradiation or chemotherapy, length of surgery, blood loss and anesthetic risks, pain, and the tendency for the surgeon to want the patient to undergo a less complicated procedure.^{5, 7, 13}

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Introduction

Society places a tremendous value on breasts and on the physical appearance of women in general. The patient with breast cancer faces not only the diagnosis of malignancy but also the probable loss of the breast.^{1, 2} Considerable psychosocial trauma may follow mastectomy for breast cancer.

In the last two decades, the concept of breast reconstruction has become an integral consideration in the management of breast cancer.³ Large numbers of procedures with both immediate and delayed approaches have demonstrated both oncologic safety and acceptable technical and aesthetic outcomes of breast reconstruction.⁴⁻¹⁰

Methods

From August 1988 through October 1989, 11 women underwent immediate breast reconstruction by the first author at the time of mastectomy for breast cancer at the University of Kentucky Medical Center. They ranged in age from 34-60 years, averaging 43.6 years of age. Three patients had Stage I carcinoma and eight had Stage II carcinoma at the time of the procedure. Seven women underwent unilateral mastectomy. Four women underwent bilateral mastectomies at the initial surgery, the contralateral mastectomy being prophylactic. Therefore, 15 breasts underwent immediate reconstruction. Three reconstructions

Immediate Breast Reconstruction

Table 1

Patient No.	Age	Days in Hospital	Procedure	Stage	Adjuvant Therapy	Complications	Return to Normal Activity (Weeks)
1	40	6	TRAM	II	Cytosan, Methotrexate, 5-FU (post-op)	None	3
2	45	11	Free TRAM	II	Tamoxifen	Incisional Hernia; metastatic disease 12 mos. post-mastectomy	24
3	50	8	Free TRAM	I	None	Transient Partial Median Sensory Neuropathy, Pneumonia	7
4	34	7	TRAM with Implant	II	Tamoxifen	Partial Flap Necrosis (2×4 cm)	5
5	60	7	Free TRAM	II	Tamoxifen	None	6
6	39	9	Latissimus Dorsi with Implant	II	Adriamycin/ Cytosan (pre-op)	Partial Flap Necrosis (3 cm)	8
7	52	7	Bilateral TRAM with Implants	II	Tamoxifen	Seroma-Axilla	3
8	39	5	Bilateral Subpectoral Implants	I	Cytosan, Methotrexate 5-FU (post-op)	Loss of Prosthesis	4
9	40	7	Bilateral TRAM with Implants	II	Adriamycin/ Cytosan (post-op)	None	3
10	43	5	TRAM with Implant	II	Tamoxifen	None	9
11	44	6	Bilateral TRAM with Implants	I	Tamoxifen	None	6

utilized free transverse rectus abdominis myocutaneous flaps (free TRAM), nine utilized standard transverse rectus abdominis myocutaneous flaps (TRAM), and two involved insertion of silicon gel subpectoral implants. One patient underwent a procedure involving a latissimus dorsi flap. No patients were refused immediate breast reconstruction because of clinical stage, location of tumor, age, or financial status. All patients were in good general physical health. No patient received radiotherapy.

Results

Patients were followed for a minimum of 18 to a maximum of 32 months. The mean follow-up was 26 months. One patient (No. 2) developed metastatic disease 12 months post-mastectomy. The presence of the reconstruction did not interfere with diagnosis of this metastasis. Patient No. 7 moved out of state and was lost to follow-up at 7 months post-mastectomy. All other patients are alive without evidence of metastatic disease or local recurrence. In no patient was the initiation

of adjuvant chemotherapy or hormonal therapy delayed due to complications of reconstruction.

Table 1 describes each patient in this series including age, number of days in hospital, procedure, stage of cancer, adjuvant chemotherapy, complications, and number of weeks of convalescence required before returning to normal activity. Complications at the mastectomy and tissue donor sites are listed in Table 2. One patient lost her prosthesis 5 weeks after surgery due to exposure of the implant. The patient elected to defer further reconstruction until the completion of chemotherapy. Photographs of patients No. 2 and No. 11 illustrate pre-operative and post-operative views (Figs 1 and 2).

Discussion

Concerns about the safety of breast reconstruction in the breast cancer patient have diminished over time. At the University of Kentucky Medical Center, immediate reconstruction is one treatment option offered to each suitable patient with the diagnosis of operable breast cancer. Women

Table 2. Complications at Mastectomy/Reconstruction or Donor Site

Implant loss	1/11
Capsular contracture	0/11
Wound infection	0/15
Seroma	1/15
Partial flap loss	2/15

with breast cancer are treated by a team approach. The team includes the surgical oncologist, radiologist, pathologist, medical oncologist, and radiation oncologist.³ The plastic and reconstructive surgeon has also become an integral member of this team.

In general, when a patient is diagnosed as having breast cancer, the surgical oncologist gives her the choice of undergoing a modified radical mastectomy for control of the primary tumor or, if appropriate, of undergoing lumpectomy with axillary node dissection followed by radiotherapy. All patients choosing mastectomy are then offered a consultation with a plastic and reconstructive surgeon regarding the option of immediate reconstruction. The patient meets with the plastic and reconstructive surgeon, who presents the various reconstructive options and fully discusses the procedure, the expected outcome, and potential risks and complications. In addition, the patient views a slide presentation on breast reconstruction developed by the American Cancer Society.¹⁴

Most complications in breast reconstruction involve minor necrosis of wound margins which heals rapidly with conservative treatment. Seromas often resolve spontaneously or may require aspiration.⁷ The recurrence rate of breast cancer in the patient who has undergone reconstruction is unchanged from that seen in patients undergoing mastectomy alone.^{7, 10} In general, implants do not interfere with the detection or treatment of cancer recurrence.^{7, 10, 13} There has been, however, one reported case of a 3-month delay in detection of local cancer recurrence which may have been due to physician error.⁴ This occurred in a patient who underwent a delayed TRAM procedure.

In 5% to 15% of cases, mastectomy is associated with complications, such as seromas (4%),²³ skin necrosis (8%),²⁴ and infection (8%).²⁵ In our series, the complications of axillary seroma, pneu-

monia, and transient peripheral sensory neuropathy may well have been seen had the patients undergone modified radical mastectomy alone. The complications unique to the reconstructive procedure were the implant loss due to implant exposure secondary to wound dehiscence in patient No. 8, the incisional hernia in patient No. 2, and partial flap loss in patients No. 4 and No. 6. In patient No. 8 the wound was closed under moderate tension. Patients No. 4 and No. 6 were returned to surgery where debridement of the necrotic edge of the flap was performed. The wounds were closed at the time of surgery and healed primarily. In the latter patient, the partial flap loss was likely due to extension of the flap beyond its vascular territory. Her preoperative course of chemotherapy may have been a contributing factor. There were no wound infections. Capsular contractions have not developed in those cases involving implants alone. These complications fall within the expected incidence of complications seen in other larger reviews of immediate reconstruction.^{4, 7, 9, 26, 27} Most important, the complications seen are not in excess of those seen in patients undergoing delayed reconstruction.⁴

As revealed by a review of the literature, the majority of patients who have undergone immediate breast reconstruction are Stage I and II cancer patients. Some Stage III patients have undergone immediate breast reconstruction without untoward consequences. The issue of immediate breast reconstruction in Stage III patients is best addressed between the patient and her physician.

The incidence of positive margins following modified radical mastectomy is extremely low. The surgeon may elect to treat the patient with radiotherapy or return to the operating room for further resection. In either case, the presence of a reconstruction does not interfere with this option. Should disease be identified infiltrating the chest wall at the time of modified radical mastectomy, the surgeon always has the prerogative of declining immediate breast reconstruction. This is a very rare occurrence. One large series failed to demonstrate a single case in which the presence of breast reconstruction interfered with the treatment of a local recurrence.⁷

Immediate reconstruction is technically appealing to the reconstructive surgeon because it allows an accurate match of the skin and breast tissue removed. Breast skin is not unnecessarily sacrificed, as it otherwise would be to accomplish wound closure without "dog ears." The skin bras-

Immediate Breast Reconstruction

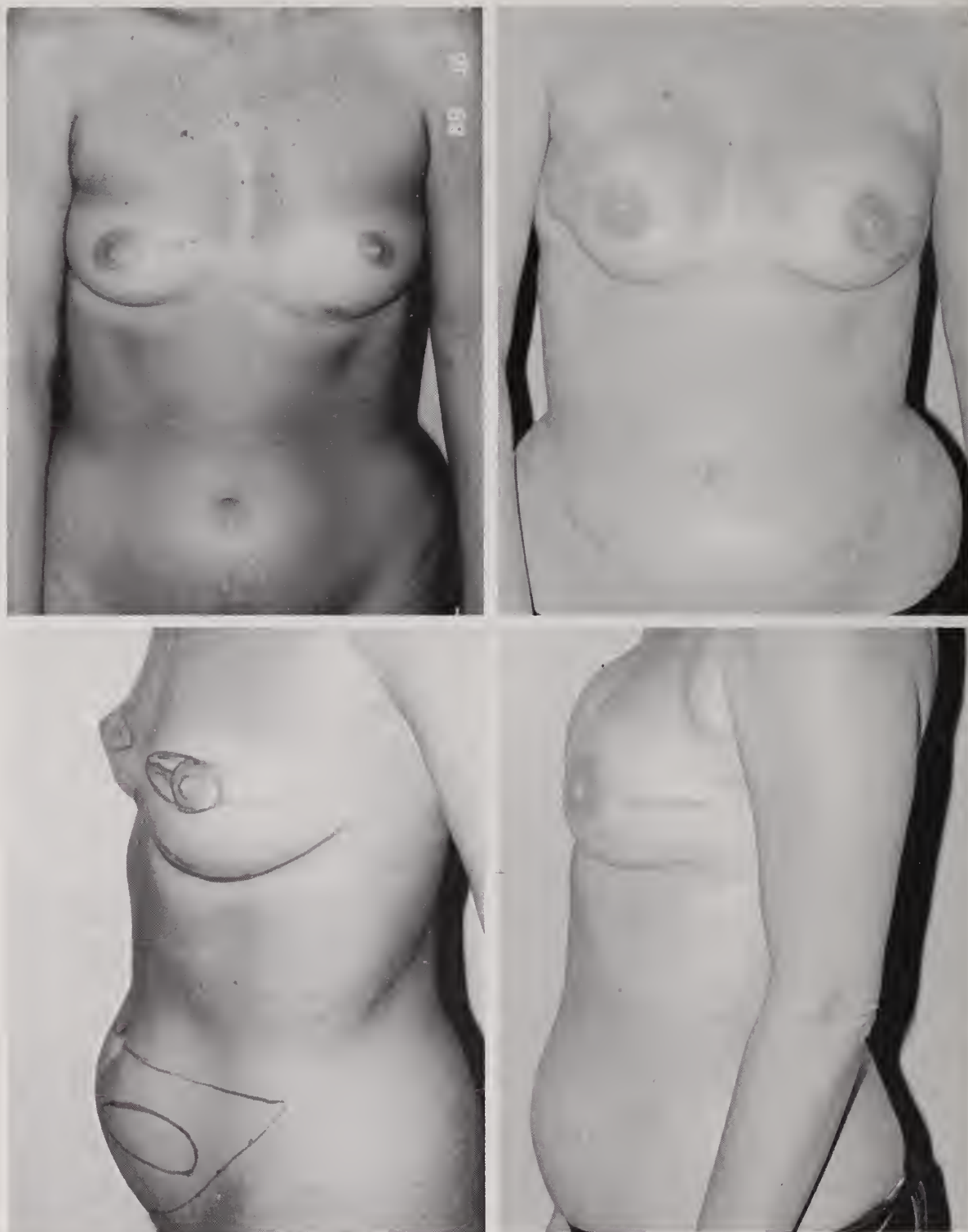


Fig 1 — A: Front view of a 45-year-old woman before right modified radical mastectomy and left simple mastectomy. **B:** Thirty months following bilateral, immediate breast reconstruction with TRAM flaps and submuscular implants. **C:** Preoperative lateral view. **D:** Postoperative lateral view.

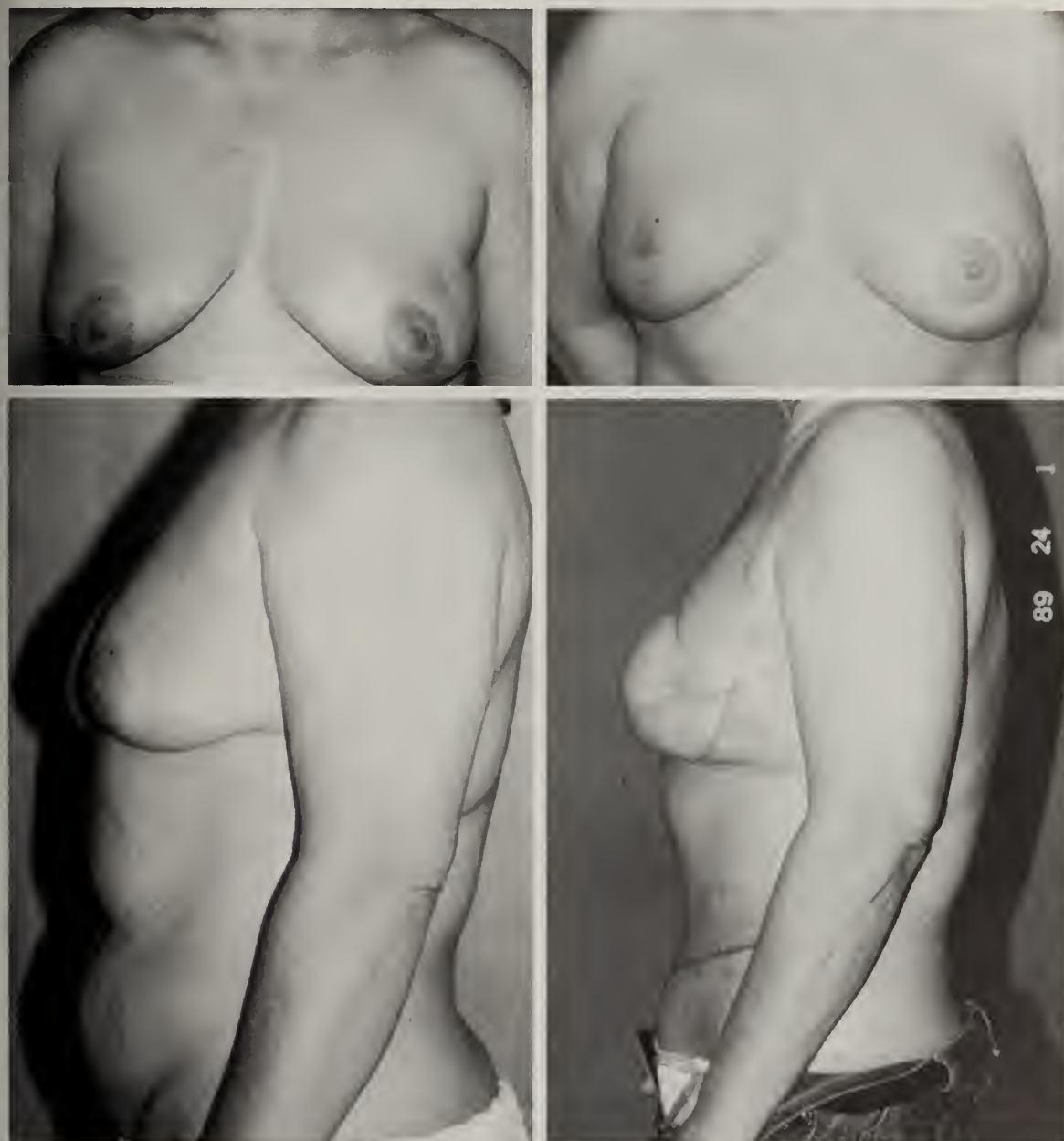


Fig 2 — A: Front view of a 45-year-old woman before left modified radical mastectomy. **B:** Seventeen months following left immediate free TRAM breast reconstruction and right breast augmentation/mastopexy. **C:** Preoperative lateral view. **D:** Postoperative lateral view.

Immediate Breast Reconstruction

sire is maintained at maximum stretch.^{6,13} While operating time is increased by the performance of immediate reconstruction, the total operating time is believed to be less than the additional time involved in delayed reconstruction. Morbidity may be decreased by the elimination of a second hospitalization, anesthetic, and operation when a delayed procedure is selected. Patients find immediate reconstruction more appealing because they prefer not to undergo the pain and inconvenience of an additional operative procedure.

Several alterations in psychosocial function have been noted in post-mastectomy patients. Body image is affected; women experience a diminished sense of wholeness and a sense of body asymmetry and deformity. Many women feel mutilated; thus, their perception of their sexual attractiveness and desirability is diminished. This feeling may lead to fear of sexual rejection at a time when the need for affection and sexual attention is actually heightened.¹⁵ The change in bodily appearance leads to embarrassment and inhibition of normal activities.¹⁶

In addition to the perception of physical deformity, there are also other psychological sequelae of mastectomy. Many patients experience loss of self-esteem and feelings of depression, anxiety, anger, and guilt. Fear of death is common and related to the "national cancerphobia" which has developed in the population of the United States.¹⁷ Increased use of alcohol and tranquilizers has been seen in mastectomy patients.^{15,16,18}

Reconstruction of the breast is one of the best alternative treatments for dealing with the trauma associated with a disfiguring mastectomy.^{16,20} Much psychosocial suffering can be avoided or lessened by immediate reconstruction.^{6,12} Those women undergoing immediate reconstruction exhibit less self-consciousness than those undergoing mastectomy. Patients are spared the necessity of camouflaging and confronting the chest defect. Immediate reconstruction obviates the need for an external prosthesis with its undesirable attributes.¹² Patients feel as though they have had their "parts rearranged" rather than removed.²¹ The reconstructed breast is experienced as a natural part of the body, enabling the patient to feel whole, not deformed.²² Patients who have undergone reconstruction are less depressed and resume sexual relations earlier than those who have not undergone such a procedure.¹⁸

Conclusion

Immediate breast reconstruction has become a viable option in the management of breast cancer. The oncologic surgeon can recommend immediate breast reconstruction without concern that the initiation of chemotherapy, if indicated, will be delayed. In this and other studies, the safety of immediate breast reconstruction compares favorably with that of delayed reconstruction. The emotional well-being of the patient is enhanced, and cosmetic outcomes are good. Depending on the reconstructive technique, the total length of hospital stay and convalescence are only minimally increased. Immediate breast reconstruction at the time of mastectomy is safe and should be offered to newly diagnosed breast cancer patients.

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Interdisciplinary Treatment of Abused Families in Kentucky

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The recognition and management of child sexual abuse has gained increased attention by primary care physicians. Examined are the results of a 3-year interdisciplinary clinical treatment program and clinical data which enhance the primary care physician's assessment and management of child sexual abuse. Specific criteria used in diagnosis and strategies for abuse are explored. Psychological factors involved in the adaptation process and long-term impact on the child and family are discussed.

Introduction

The medical community has realized an increased recognition of child sexual abuse and its impact on the lives of both the child and family members.¹ Nationally, more than 2.4 million cases of child abuse including child sexual abuse were recorded during 1989.² In this rural Kentucky county, 1989 data reported more than 300 cases of alleged sexual abuse. A neighboring county nearly five times larger in population reported nearly 500 cases of sexually abused children. The entire Commonwealth of Kentucky, as reported by the Human Resources Cabinet, realized 32,643 complaints of children being sexually abused during the last fiscal year.

A national epidemiological survey³ has provided convincing evidence that child sexual abuse may well be occurring at even higher rates than reported. The National Center on Child Abuse and Neglect reports that the true extent of the problem of sexual abuse of children may not actually be known. Most data comes from large, urban areas and much less is known about rural communities. It is estimated, however, that between 10% and 25% of all preadolescent females and males have had some sexual contact with perpetrators. One study indicates that 19% of fe-

males and 9% of males have been sexually abused prior to the age of 12 by a person at least 5 years their senior. Close to one third of all college students studied indicated they had been sexually abused, and 38% of females before age 18 had sexual abuse experiences involving physical contact. What is more clear is that sexual abuse, like other forms of abuse, is seriously underreported.⁴

Methodology

The Cabinet for Human Resources (CHR), Commonwealth of Kentucky, supported the study of the effectiveness of a joint venture between the Department of Psychiatry and the Department of Family Medicine, University of Kentucky. This program was aimed at providing necessary services to victims of child and sexual abuse from the Commonwealth of Kentucky. Referrals for this program came to both the Family Practice Sexual Abuse Clinic and the Child Psychiatry Child Abuse Clinic of the University of Kentucky Medical Center. Provided were clinical evaluation services, medical evaluation, individual counseling and psychotherapy, group counseling and psychotherapy, marital treatment sessions, and family treatment sessions. Beyond the direct patient care services, also provided were professional training sessions to medical and health care professionals throughout the commonwealth. Efforts to provide immediate response to referrals for both evaluation and treatment were made, with the provision that there be no waiting list.

Results

This 2-year study realized 628 new referrals. These referrals were to both the Family Practice Sexual Abuse Clinic and the Child Psychiatry Child Abuse Clinic, University of Kentucky Medical Center, Lexington, Kentucky. This number repre-

sents an average of 26.17 referrals per month. The total number of clients served during the 2-year report period was 1,351, with an average monthly rate of 56.29. The number of families served for clinical evaluations during this time period involved 203 families, with 277 medical evaluations completed through the Family Practice Clinic and 243 individual treatment sessions provided through the Child Psychiatry Child Abuse Clinic during the report period.

The total number of client contacts, both medical and clinical, times the number of sessions provided realized 2,310, or 96.25 per month. The need to provide family treatment in the course of evaluating the abuse referrals realized 168 family treatment sessions offered, 10 marital treatment sessions, and 67 group treatment sessions during the report period. The statistical results of this are summarized by year totals and average per month in Table 1.

Professional Training

A core ingredient in the development and implementation of this project was the development of a professional training component which would provide both medical and clinically relevant material to professionals in the field. A total of 80 professional training sessions were provided during the 2-year report period, with an average 3.33 per month. In the first year of the study, 1,915 received training, for a total of 2,624 within-state professionals being trained during the report period. This averaged a total of 109.33 per month. Data results completed on the sexual abuse evaluation and management portion of the program yielded an overall rating of 4.59 on a 5-point scale. A majority of components included written comments suggesting that the materials presented were extremely useful, excellent, and practical.

Community Outreach

Professional contacts, including consultations and referrals, to the program from outside agencies, both medical and clinical, totaled 238, or 9.92 per month. Sixty-eight percent of all referrals came from the Department of Social Services, 12% from family members, and the remaining 20% from community agencies. Fifty-six percent of all patients referred had a history of sexual abuse. Twenty-five percent showed abnormalities of the external genitals, 40% of the females had hymenal abnormalities, and 14% of the children had ab-

Table 1. Statistical Summary for Interdisciplinary Treatment of Abusive Families

Cotegary	Total	Average (Per Month)
1. New Referrals	628	26.17
2. Clients Served	1,351	56.29
3. Families Served	767	31.96
4. Clinical Evaluations	203	8.46
5. Medical Evaluations (Each family member seporote)	277	11.54
6. Individul Tx Sessions	243	10.13
7. Group Tx Sessions	67	2.79
8. Marital Tx Sessions	10	0.42
9. Family Tx Sessions	168	7.0
10. Total Medical & Clinical Contacts (Each family member separate) (This no. of patients \times no. of sessions)	2,310	96.25
11. Clients Terminated (Clinical only – 1 Family = 1)	217	9.04
12. No. on Waiting List	0	0
13. Professional Contacts Outside Agency (Medical & Clinical)	238	9.92
14. Hours of Court Involvement	108	4.5
15. Professional Training Sessions (Medical & Clinical)	80	3.33
16. Professionals Receiving Training (Medical & Clinical)	2,624	109.33

normal rectal exams. Twenty percent of those referred were male, 80% were female, with the age range from 7 months to 17 years, and a mean age of 6.6 years. A review by counties revealed that patient referrals came from 47 separate counties in the Commonwealth of Kentucky, with the highest rates from Fayette County, Jefferson County, and Bourbon County.

Follow-Up Analysis

In January and February 1991, a representative follow-up telephone survey yielded the following results with respect to: (1) whether the clinic services were used by the county program; (2) whether both the medical (Family Practice) and psychological services (Psychiatry) clinics were used; (3) what was the perception of accessibility to consultation; and (4) any recommendations. Results reveal the following:

1. Eighteen offices contacted in 15 counties. All used the services of the program.
2. Two offices did not use the program. These were in Nicholas and Powell Counties.
3. Seventeen counties in the Bluegrass area used the program's services.

Treatment of Abused Families

Table 2. Sexual Abuse by Type and Physical/Behavioral Indicators**Types of Sexual Activities**

Fondling and caressing
Using the child for stimulation
Sexual stimulation
Sexual exploitation
Intercourse
Oral/genital contact

Physical Indicators of Sexual Abuse

Complaints of pain, itching or irritation in the genital area
Evidence of trauma of the mouth, anus, external genitalia or vaginal area
Torn, stained or bloody underclothing
Presence of semen
Pregnancy, especially in early adolescence
Venereal disease
Difficulty in walking or sitting

Behavioral Indicators of Sexual Abuse

Hyperactivity
Withdrawal
Poor peer relationships
Hostility/aggression
Drug/alcohol abuse
Precocious sexual behavior
Sophisticated sexual knowledge beyond the child's age
Agitation
Regression
School problems
Running away from home
Delinquency
Compulsive masturbation
Daydreaming
Nightmares

faction with the services provided and realized recommendations for future planning.

The recognition and diagnosis of sexual abuse by the primary care physician requires a clear understanding of the types of sexual activities, the physical indicators of sexual abuse, and the behavioral indicators of sexual abuse.^{5,6} Summarized in Table 2 are these indices. In addition, there are specific criteria that are useful in determining the degree of psychological harm experienced by the sexually abused child. Table 2.

Perhaps the most useful criteria available to the primary care physician in assessing the presence of child abuse are those symptoms reported during the physical examination of a child. On the surface, they may not be explicit indicators of child abuse; however, it is imperative that the physician remain open to a hypothesis that these symptoms may be an indicator of physical, emotional, or sexual abuse.

Processing Trauma in Abuse

The trauma of child abuse and in particular sexual abuse has been addressed in the psychiatric literature.^{7,8} Clinicians have come to understand some of the real or anticipated traumas experienced by children who are the objects of sexual abuse.⁹ Summit¹⁰ notes a "Child Sexual Abuse Accommodation Syndrome" which suggests that the sexually abused child is often fearful and confused about the outcome of disclosure. Adults, including parents, health care professionals, and the courts, often offer little support, and in fact tend to disbelieve the child. A typical response is that the child's story is merely fantasy, confusion, or displacement of the child's own wish for seductive conquest. The sexually abused child responds in a contradictory and unexpected manner — unexpected, that is, from the adult perspective. The following are the five categories of the syndrome suggested by Summit: (1) secrecy, (2) helplessness, (3) accommodation, (4) delayed, conflicted, and unconvincing testimony, and (5) retraction — the child is likely to reverse their story because of ambivalence, obligation to preserve the family, and fear.

Similarly, Miller and Velkamp¹¹ note that the child confronted with sexual victimization often passes through a series of stages in dealing with this trauma. The initial stage of the victimization which is recognized as the stressor usually realizes an acute physical and/or psychological trauma. The child's response is usually one of

4. Fifteen of the 18 counties used both the Family Practice and Psychiatry Clinics.
5. The mean accessibility rating on a 5-point scale with "5" indicating the highest level of satisfaction was $X = 4.7$.

Discussion

The interdisciplinary program provided clinical services, including screening and assessment in the course of the 2-year period, October 1989 through September 1990, to 1,351 patients. The total number of client contacts, both medical and clinical, was 2,310, with an average of 96.25 per month. Sixty-eight percent of the referrals came from the Department of Social Services (DSS), 20% from community agencies, and 12% from families themselves. Eighty professional training experiences were provided over the 2-year period, with a considerably favorable response from the 2,624 within-state professionals who received the training. A follow-up referral clinic satisfaction survey completed in February 1991 yielded satis-

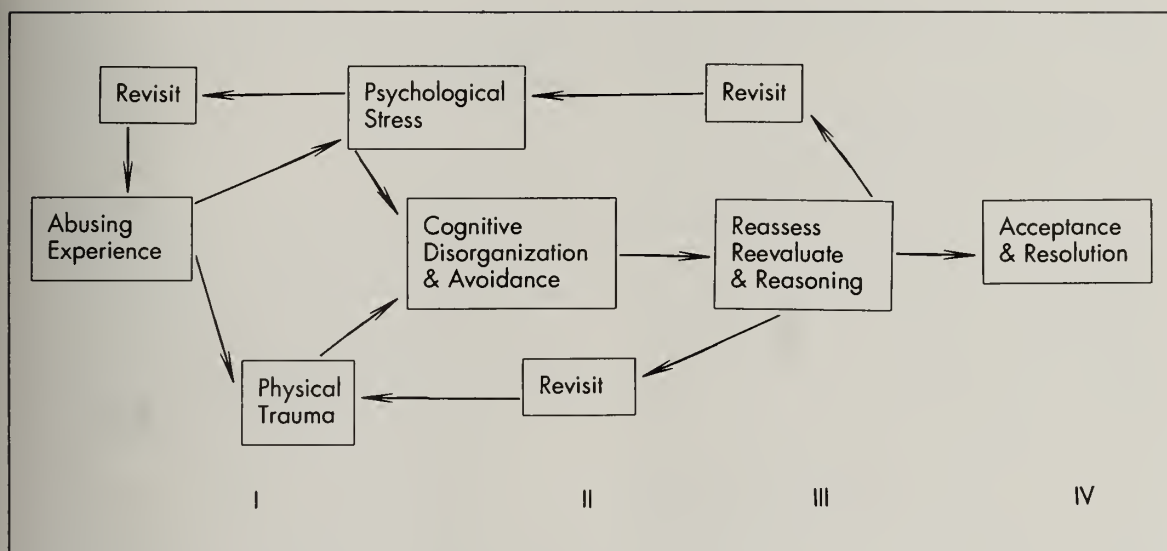


Fig 1 — Stages of Experiencing Sexual Abuse and Emotional Trauma

feeling overwhelmed and intimidated and whose locus of control is more of an external nature. It is not uncommon for the child to think recurrently of the stressful experience and to focus on the intimidating act as well as physical pain associated with the act. This acute stage of trauma is followed by a stage involving more cognitive confusion. This stage is marked by a vagueness in understanding both the concept of sexual abuse and expectancies associated with the demands of the adult in the relationship (Fig 1).

The second stage involves a denial or avoidance which can take two directions and may vary on its choice at various within-phase considerations. The first is a phase of conscious inhibition where an effort is made on the part of the child to actively inhibit thoughts and feelings related to the sexual trauma. This can involve revisiting the cognitive confusion phase and the earlier memories and flashbacks to the acute physical and psychological trauma. The second phase is one of avoidance involving unconscious denial, wherein the child is not aware of his/her effort to avoid the psychological trauma associated with the sexual abuse and therefore unconsciously denies the issues and reconsideration of the sexually abusing experience and the confusion which followed. This unconscious denial less frequently allows a revisitation to the cognitive disorganization stage and the confusion phase.

The cognitive confusion phase is followed by a stage of therapeutic reassessment wherein a

parent or significant other usually supports the reasoning and reevaluation of this psychological and physical trauma associated with the sexual abuse. At this phase, the child which experiences the sexual trauma may begin to disclose through drawings or through fables or perhaps other forms of ideation clues or specific content relevant to the experiencing of the sexual abuse. The phase of therapeutic reevaluation and reasoning is significant in that it indicates that conscious adult support has been realized by the child in passing from the avoidant phase to the issues, the activities, and the trauma of the sexually abusing experience(s).

A last stage addresses acceptance and resolution wherein the child has been able through the support of parents, professionals, or significant others to deal with the issues and come to a better realization of the understanding of the significance of the abuse and to develop coping strategies which will allow the child to deal cognitively and emotionally with the abuse. The child is viewed at this stage as: (1) being more open and talking about the incident, (2) being able to express thoughts and feelings more readily, and (3) being allowed to engage in both assessment and play therapy to discharge some of the aggressive feelings toward the perpetrator, which is a health component to the process. It is clearly at this phase that the child has realized an alliance with the significant others and/or professionals in exploring the original traumatic life experience,

Treatment of Abused Families

and in dealing with both the physical and psychological stressors involved.

The Physical Examination

The examining physician is responsible for obtaining a complete history, performing a documentary physical examination, and providing appropriate medical treatment to victims of alleged child abuse. Documentation of sexual abuse is totally dependent upon the history in over two thirds of the cases. Therefore, the interview needs to be done with thoroughness and tact and recorded in the first person when possible. In addition to the usual parts of the medical history, the physician also needs to obtain a history of the sexual abuse.¹² If at all possible, the patient should be interviewed individually. Children under the age of 4 may have to be interviewed with the mother or another adult caretaker; however, older children should be interviewed alone and encouraged to tell their story in their own words.¹³ The patient should be encouraged to reveal as much detail as possible concerning the types and frequency of sexual activities, while maintaining a sensitivity to the content and difficulty this may cause the patient. If the patient describes symptoms that could be related to sexual abuse, the story must sometimes be drawn out by a question such as, "I have a feeling that maybe somebody has done something to your body that has frightened you. Why don't you tell me about it?" The child's special names for body parts may be helpful. In addition to facts regarding date, time, place, and person, the physician must document sites of sexual abuse (eg, mouth, breasts, genitals, anus). Asking the patient to point to the parts of her body that were involved, the patient's concept of intercourse, whether penetration occurred and whether ejaculation took place, should be sought and recorded. Sexually abused children have often been threatened, and it may be useful for the interviewing physician to inquire to see if they are scared or if they have any "secrets."

A complete physical examination (looking for extragenital trauma) should be completed. The child should be prepared for the genital/anal examination by a careful explanation of the examination procedure. Most children are able to cooperate for an adequate genital examination, if care has been taken to establish rapport. A child should never be restrained for the genital examination (with the possible exception of an

infant) for two reasons: (1) assault on the child by health professionals is unacceptable; and (2) it is impossible to do an inadequate genital examination on a resisting, frightened, squirming child.

Important points about the genital examination include:

1. *Positioning* — Very young (preschool) children are usually best examined in their mother's lap. Preadolescent girls should be placed in a frog-leg position.
2. *Exposure* — Adequate exposure of the female genitalia may be obtained by spreading the labia majora. This is done by placing the thumbs on the patient's buttocks and gently tensing the perineum laterally and downward.
3. *Examination of the external genitalia* — Each part of the genitalia (prepuce, labia minora, etc) should be carefully inspected, with conscious attention to the anatomy, the presence of lesions, scars, bruises, changes in pigmentation, discharge, and other abnormalities.
4. *Examination of the hymen* — The condition of the hymen should be noted, looking specifically for any scars. The size of the hymenal opening should be measured horizontally in millimeters. The physician should determine whether the hymen is intact, recently ruptured with evidence of trauma, or ruptured with no evidence of trauma. If there is evidence of recent trauma, the physician may perform a pelvic exam using an otoscope speculum. The colposcope has been proposed as an adjunct in the diagnosis of child sexual abuse. It is a noninvasive instrument which utilizes a binocular magnification system which enhances visual inspection of the genitalia. It can be used to clarify findings that have been seen during the general physical exam and to visualize additional lesions which were not able to be identified by the "naked eye" alone. Genital examination of boys is far less complicated but requires the same careful attention as that of girls.

An anal examination involves careful inspection of the anus for fissures, lacerations, thickening of the skin, skin tags or other abnormalities. Lateral traction on the buttocks may cause the anus to gape open in a child who has been sodomized a number of times. All orifices which may have come in contact with the alleged assailant's

genitalia should be cultured for gonorrhea and chlamydia. Routine cultures for syphilis, herpes, and HIV antibody testing may be of considerable value.

The examining physician's record is an important legal document. Notes may be taken during the exam, but a legible, complete chart note detailing the history, physical examination, lab results, and clinical impressions must be recorded as soon as possible in the patient's chart. Suspected/documented child sexual abuse must be reported by telephone to the appropriate state authorities as soon as it is suspected. A written report should be subsequently filed within 48 hours of the initial telephone report.

Projective Assessment of the Child

In child sexual abuse cases, particularly when the perpetrator is a family member, the child is often too troubled to talk openly about what has happened. A variety of techniques are used to ascertain how a child alleged abuse.^{14,15} The use of wishes, fables, anatomical dolls, puppets, drawings, and a variety of play therapy techniques are used by most clinicians in working with victims of sexual abuse. Considerable attention has been given to the use of drawings as a form of emotional ventilation in the evaluation process of treating sexually abused children. Drawings are particularly useful in the evaluation process because: (1) drawings can be reflective of what is preoccupying the child, (2) drawings can reveal details that indicate how the child feels about himself, others and the home situation, (3) drawings can dramatize the trauma that the child has experienced, and (4) drawings can be used as part of the court testimony. It has been our experience that once a child has drawn a picture, (s)he becomes highly verbal regarding the contents of the drawing.

Drawings may stimulate the child to refer to something that has happened — a dream, a daydream or a specific fear, even when (s)he refuses to talk about it or doesn't know how to express it in words. At this point in the evaluation, the clinician may say, "We don't have to put it into words; sometimes it's easier to draw a picture of what we feel or what has happened." We have found that silent children will often accept drawing as an alternative to talking.

The interpretation of drawings can generate hypotheses that have clinical relevance. We record primary themes, ie, themes regarding feel-

ings, the child's perspective, or specific events. Ultimately the interpretation of the drawing is based not only on what the child has drawn, but also what the child says about the drawing.

Despert,¹⁵ a French child psychiatrist, introduced the use of fables, a psychoanalytic focus, to elicit children's feelings, attitudes, and perceptions regarding a wide range of themes. Based on the efforts of Despert, a revised series of fables¹⁶ are now used as a means of understanding the complexities and readiness of a child to yield clinically relevant information in cases where life stress and personal or sexual trauma are suspected.

Treatment Considerations

Treatment objectives¹⁵ for child sexual abuse include:

1. Identify the abused child. Some children will complain directly about the assault, while others may report vague symptoms and exhibit nonspecific physical findings.
2. Obtain and record an accurate history of the assault, including the answers to the questions of who, when, what, where, and how.
3. Manage the acute medical problems of the child, including physical injury, venereal disease, and pregnancy.
4. Manage the acute emotional problems of the child and family resulting from the abuse itself, the act of disclosure, police involvement, and the medical exam. These problems are often exacerbated by mixed feelings of anger, guilt, and frustration.
5. Safeguard the child against further abuse by determining whether the child and other children at home are under unusual risk for abuse and should be placed in temporary custody.
6. Formulate a long-range treatment and follow-up plan for the child's medical and psychological needs.
7. Comply with legal requirements for collection of evidence, documentation, and depending upon the laws of a particular state, reporting of the abuse as a crime or as child abuse.

The objectives presented are best achieved through a multidisciplinary effort involving primary care physicians, specially trained psychologists, social workers, mental health care providers, the legal justice system, child protective service agencies, and community support networks.¹⁸

Issues and Implications

The impact of child sexual abuse has been associated with a wide range of psychopathology and resulting diagnostic categories. While the range of psychopathology associated with such abuse is typically anchored in anxiety disorders and depression, it may also be associated with the development of character disorders in some victims in the long-term and self-destructive behaviors. The outcome of prosecution in many cases can also be a traumatic experience for the victim. It is clear that the children who come to court and who testify in court can be emotionally traumatized by the experience itself. The opinion of most clinicians who deal with child sexual abuse is that the effects of the social and legal system may be as damaging as the sexual abuse itself. If, however, recognition and identification of the presence of abuse takes place, it is likely that the continuation of abuse can be curtailed or eliminated.

One of the most difficult issues in dealing with child sexual abuse is age-related issues, with a clear increase in the number of reports of child sexual abuse involving preschool-age children.¹⁹ It is not uncommon to find these children as part of a dysfunctional family, which is resulting in problematic and emotionally charged legal issues including separation and divorce. There are a number of factors which make cases such as these more difficult, the most notable of which include: (1) the child is usually very young and therefore a questionable reporter, and (2) the allegations of child abuse from a preschool child can raise issues related to credibility. Some of the problems that arise when child sexual abuse is alleged in the context of separation or divorce are directly related to the legal system itself. The divorce court is often an adversarial court accustomed to addressing the rights and needs of conflicting adults, whereas the juvenile court system is designed to respond to the limitations and vulnerability of children. The legal system must, therefore, appropriately respond separately and independently in such complicated cases by appropriate referral in the legal process.

What is most clear is that no discipline alone — medical, legal, or clinical — is solely responsible for what should be done with cases involving child sexual abuse. Professionals in all disciplines who interview, diagnose, and treat alleged victims of child sexual abuse must be trained in their expertise and knowledge of the problem of sexual abuse and in their familiarity in its recognition.

To that end, the primary care physician has a critically important responsibility and role.

The Primary Care Physician's Role

The role and function of the primary care physician in the assessment of child sexual abuse is critically important. Primary care physicians are often the first of the multidisciplinary team of health care professionals to have the opportunity of identifying the possibility of the presence of abuse in assessing the health care of children.

A thorough and complete evaluation of the child sexual abuse cases involves both a medical and clinical evaluation.^{20, 22} This evaluation process begins with the initial interviews conducted by the social worker or other mental health professional. A physical exam should be conducted by a physician or health care provider who has experience in this area.

A physical examination can be important when there is evidence of physical or sexual abuse or neglect. It is important to make the child as comfortable as possible during the physical exam. The physical exam should determine if the child is pregnant, if the child has a sexually transmitted disease, and/or if there are any tears, scars, or lacerations. Thus, although a physical exam may provide specific evidence indicating that abuse has occurred, it can also be helpful to reassure the child that he or she is "okay" and that nothing permanently damaging has occurred to them.

Sexually abused children generally display no physical evidence of abuse. In fact, studies indicate that only about one third of all sexually abused children display any signs of physical trauma. Use of the colposcope has become an important adjunct in the diagnosis of child sexual abuse.

The primary care physician experienced in detecting physical symptoms and behavioral indicators of potential abuse can also help evaluate the dynamics within the family and provide essential medical and health care to the abused child or children. Furthermore, the physician can sensitize and alert other health care professionals and the prospective service system of needed care for the sexually abused child.

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Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H₂-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H₂-receptor antagonists.

Precautions: General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

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Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

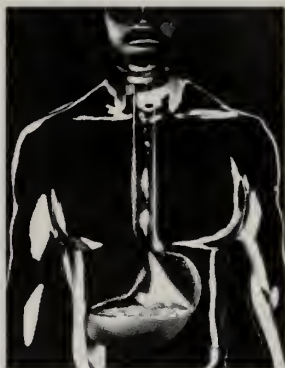
Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method. PV 2093 AMP [101591]

Additional information available to the profession on request.



Health and Safety Tip From the American Medical Association

MARKERS LISTED TO IDENTIFY ALCOHOLICS

How can you tell that a regular, heavy drinker has crossed over the line and become an alcoholic, who no longer can control his or her drinking?

The American Medical Association in its Manual on Alcoholism points to some markers to help identify the alcoholic.

1. Increasing consumption of alcohol, with frequent, perhaps unintended, episodes of intoxication.
2. Drinking to handle problems or relieve symptoms.
3. Obvious preoccupation with alcohol and the frequent need to have a drink.
4. Surreptitious drinking or gulping of drinks.
5. Tendency toward making alibis and weak excuses for drinking.
6. Refusal to concede what is obviously excessive consumption and expressing annoyance when the subject is mentioned.
7. Frequent absenteeism from the job, especially following weekends and holidays.
8. Repeated changes in jobs, particularly if to successively lower levels, or employment in a capacity beneath ability, education, and background.
9. Shabby appearance, poor hygiene, and behavior and social adjustment inconsistent with previous levels or expectations.
10. Persistent vague physical complaints without apparent cause, particularly insomnia, stomach upsets, headaches, loss of appetite.
11. Multiple contacts with the health care system with disorders that are alcohol caused or related.
12. Persistent marital and family problems, perhaps with multiple marriages.
13. History of arrests for drunkenness or drunken driving.

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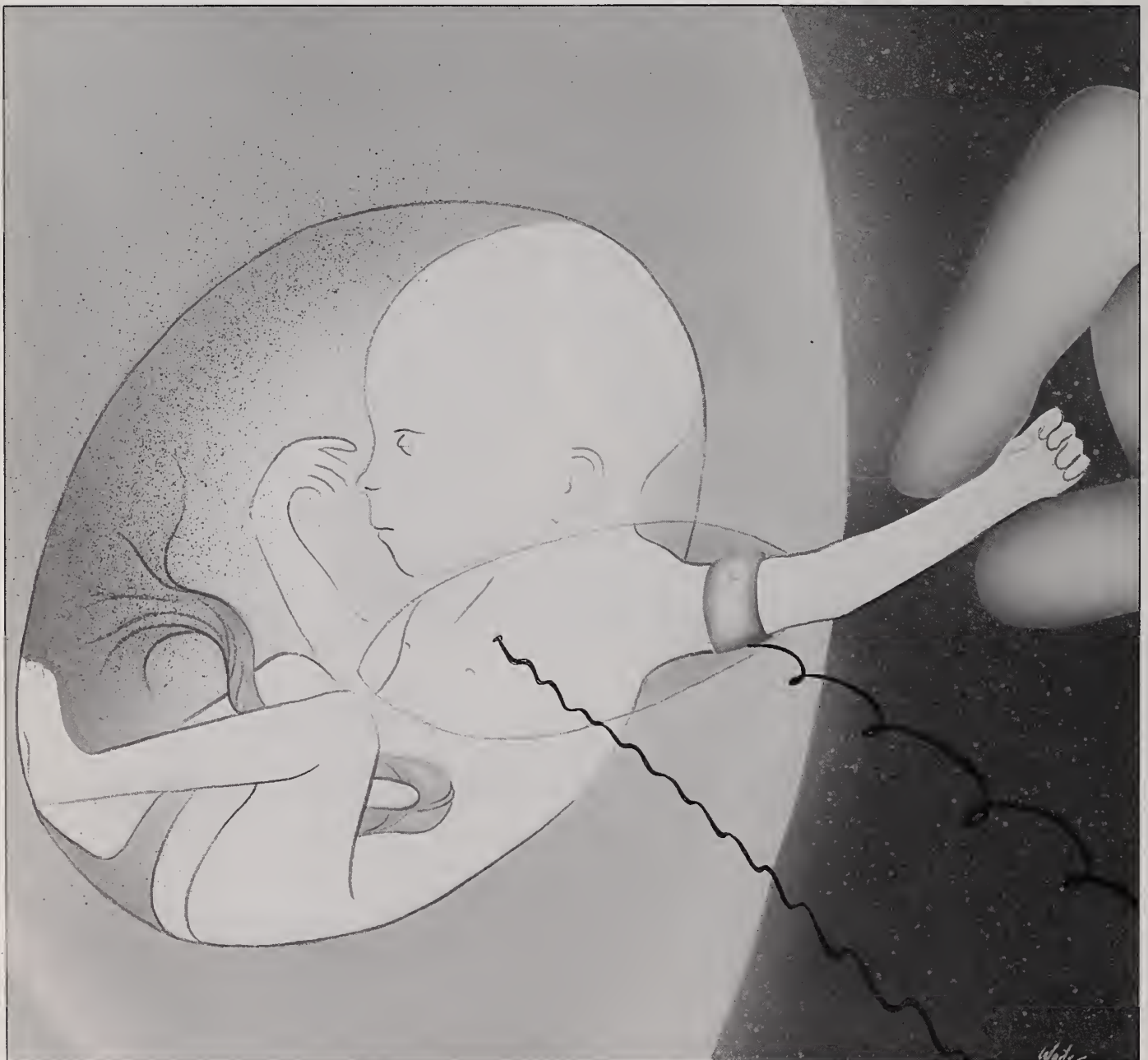
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Fetal Surgery: Correction of Anatomic and Constitutional Defects

Sheldon J. Bond, MD



The advent of improved obstetrical care and innovative advances in fetal diagnostic techniques have mandated multidisciplinary approaches to pregnancies that are complicated by prenatally diagnosed defects. The concept of fetal therapy, previously limited to in utero transfusions for Rh disease and induction of lung maturation, has now been extended to open fetal correction of congenital hydronephrosis, diaphragmatic hernia, and sacrococcygeal teratoma. Additional inquiries are now being made into the possibility of hematopoietic stem cell transplantation in utero as well as prenatal gene therapy. Continued investigation into these therapeutic interventions largely revolves around improving their efficacy and guaranteeing the safety of the mother and her unborn child.

Introduction

Pediatric surgeons frequently encounter congenital anomalies that are produced early in gestation and often result in irreversible end-organ failure at parturition. Likewise, pediatricians treat many patients with inherited hematologic dyscrasias, in which ill effects are perpetuated throughout the lifetime of the child. Modern diagnostic methods have allowed us to diagnose many of these anatomic and constitutional defects early in gestation, which can have a profound effect on the outcome of the expectant mother and unborn child.

The University of Louisville is one of a growing number of institutions with fetal treatment programs. These programs are usually comprised of multidisciplinary groups that, on a periodic basis, review anomalies diagnosed *in utero*. Currently, the function of these groups is largely advisory. They inform expectant parents about the nature of the congenital anomaly, its natural history, the efficacy of therapy, and the role of any specific obstetrical intervention such as caesarean section. The greatest benefit of these "fetal boards"

is that babies with high risk congenital anomalies, such as diaphragmatic hernia, are delivered at institutions that are capable of administering appropriate care.

Current prenatal intervention has been largely limited to steroid administration to induce lung maturation and intrauterine transfusion. However, recent advances in open fetal surgery have made correction of certain structural anomalies feasible. We now need to answer whether there is any benefit to the correction of these anomalies *in utero*, interrupting the progressive end-organ damage that is all too familiar.

History of Fetal Therapy

Scientists have long been fascinated with the concept of fetal intervention. The gravid uterus was considered inviolate until 1884¹ when the feasibility of open fetal surgery in animals was demonstrated. Since then, various models of inherited disease have been experimentally reproduced. In 1950, Louw and Barnard² reproduced intestinal atresias by ligating mesenteric artery branches.

The Fetal Treatment Program at the University of California, San Francisco, under the direction of Michael Harrison, has been active in both laboratory and clinical investigation in the diagnosis and treatment of inherited congenital defects. From 1960 to 1980, models for diaphragmatic hernia, hydronephrosis, and hydrocephalus originated in his laboratory.¹

The prenatal diagnosis of congenital anomalies has been aided by the discovery of three diagnostic techniques:¹ (1) the first obstetrical ultrasound reported by Donald in 1950; (2) amniocentesis instituted in 1953 by Bevis for the diagnosis of newborn hemolytic diseases and; (3) chorionic villus sampling discovered by Sinoni and Gustavii in 1984. Chorionic villus sampling allows diagnosis much earlier in gestation than amniocentesis, and, when combined with DNA analysis, is a powerful tool for diagnosing inher-

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Fetal Surgery

ited blood dyscrasias and other enzymatic defects.

The first successful prenatal intervention occurred in 1963 when Liley³ performed intrauterine transfusion in babies with severe Rh disease. Liggins and Howie⁴ conducted a controlled trial in 1972 which showed that maternal glucocorticoid treatment could accelerate lung maturation and prevent respiratory distress syndrome in newborns. Fetal tachycardia can now be treated *in utero* as well as some enzymatic defects.

Open fetal surgery was first performed in the 1960s on a small group of patients that underwent direct intravenous transfusion for Rh disease (unpublished data). The results of this were uniformly unsuccessful and have now been supplanted by the ability to access the fetal circulation with closed techniques by introducing needles into the umbilical cord near its placental insertion.

In 1981 Harrison et al¹ achieved the first successful antenatal open correction of an inherited congenital defect when they performed bilateral ureterostomies for posterior urethral valves. Since then, his group has performed additional urologic procedures as well as repair of congenital diaphragmatic hernia *in utero*.⁵

Correction of Anatomic Lesions

Congenital Hydronephrosis

Congenital hydronephrosis can be unilateral or bilateral, involving upper or lower urinary tract obstruction, with varying degrees of renal damage. Pulmonary development is dependent on adequate amniotic fluid volume, and most amniotic fluid is actually fetal urine. In cases of bilateral obstruction, decreasing amounts of urine output and subsequent lower amniotic fluid volumes impair pulmonary development to such a degree that hypoplastic lungs are present at birth, and survival is not possible. For these fetuses, *in utero* intervention has been contemplated. The feasibility of this was first demonstrated in the fetal lamb model in which obstructed but then corrected groups were compared with obstructed unrepaired controls.⁶ The corrected groups demonstrated improvements in urinary tract dilatation, lung weight, and air capacity.

Observation of the natural history of fetal hydronephrosis has narrowed the spectrum for which intrauterine therapy may be indicated.⁷ Criteria have been developed by Harrison's group to help select those fetuses who may benefit from

such correction: (1) the defect must affect both kidneys, (2) no other congenital anomalies can be present, (3) normal karyotype is essential, and (4) there must be an attenuation in the amount of amniotic fluid over serial ultrasonic examinations. Criteria 4 is extremely important because many kidneys are already dysplastic, and even if the obstruction is relieved, not enough urine will be produced to reconstitute the amniotic fluid volume and prevent pulmonary hypoplasia. Sonography and fetal urinalysis can be used to evaluate renal damage. The sonographic appearance of dysplastic kidneys is typically more echogenic and cystic, and these findings indicate irretrievable damage. Highly concentrated fetal urine with sodium >100 mmol/ml or osmolarity >210 are also consistent with irretrievable renal damage.

Based on these criteria, the ideal candidate for fetal urinary tract intervention are those fetuses with isolated bilateral obstructive uropathy, decreasing amounts of amniotic fluid on serial sonography, and normal renal function determined by urinalysis with a catheter introduced into the fetal bladder (Fig 1).

When the pregnancy is a few weeks away from gestational age when *ex utero* survival is guaranteed, a temporary catheter may be placed into the bladder if a low obstruction is present to reconstitute amniotic fluid volume. Success with these catheters has been limited to short intervals because of plugging and actual removal of the catheter by the fetus itself. If a longer period of time is involved, an open corrective procedure may be contemplated. In the most recent series, out of 200 cases of bilateral fetal hydronephrosis, five open surgical procedures were performed at the University of California, San Francisco.⁸ They reported two deaths from renal dysplasia and pulmonary hypoplasia. These deaths occurred during the introductory years of this technique and these fetuses would not have met current selection criteria due to advanced renal disease. Two babies were born with normal renal and pulmonary function and a third survivor currently has normal pulmonary function but suffers from renal insufficiency and is being considered for renal transplantation. Their conclusions were that fetal surgery was safe in experienced hands and that open urinary tract decompression can restore amniotic fluid dynamics and prevent pulmonary hypoplasia in a small group of selected patients. Based on that study, amniotic fluid volume can be reconstituted to ensure lung growth. Questions still arise, however. Does antenatal correction

translate into conservation of functional renal tissue?

Diaphragmatic Hernia

Congenital diaphragmatic hernia has a 50% mortality rate, and it is estimated that extracorporeal membrane oxygenation (ECMO) has improved this mortality by 10% to 15% (personal communication). Out of all the congenital anatomic defects encountered, one would expect fetuses with congenital diaphragmatic hernia to benefit the most from *in utero* correction. The defect in the diaphragm is thought to occur by the 10th to 12th week of gestation. The herniated viscera causes pulmonary hypoplasia not only on the affected side but on the contralateral side as well due to mediastinal shift. Many of these babies are thought to be born without enough lung tissue to effect gas exchange and survive despite maximal medical therapy, including ECMO. Can *in utero* reduction and repair of the hernia effectively improve lung development and prevent pulmonary hypoplasia?

The first animal model⁹ of this defect used an intrathoracic balloon to simulate the herniated viscera. Later, actual construction of the anatomic defect was created by opening the diaphragm. In subsequent studies,¹⁰ this defect was corrected in a second fetal surgery. Lung weights and air capacity appeared to be different between corrected and uncorrected fetuses, indicating that correction did allow for further progression of lung development. We also learned from these experiments that the correction of congenital diaphragmatic hernia *in utero* had a distinct difference from postnatal correction because of maternal-fetal circulatory considerations. If the abdominal viscera are returned to the abdomen after correction of the diaphragmatic defect, increased abdominal pressure obstructs the umbilical vein, resulting in cardiovascular collapse. To prevent this, an abdominal patch has been used to expand the abdominal cavity and prevent obstruction of umbilical venous return.¹¹

In 1990 the first two successful cases of congenital diaphragmatic hernia repaired *in utero* were published⁵ (Figs 2 and 3). These two successes followed six initial failures. Two of these first six died several weeks after birth, one of endotracheal tube dislodgement and the other of intestinal perforation with sepsis.

Harrison's group has currently received a National Institute of Health grant to randomize treatment of congenital diaphragmatic hernia to *in*

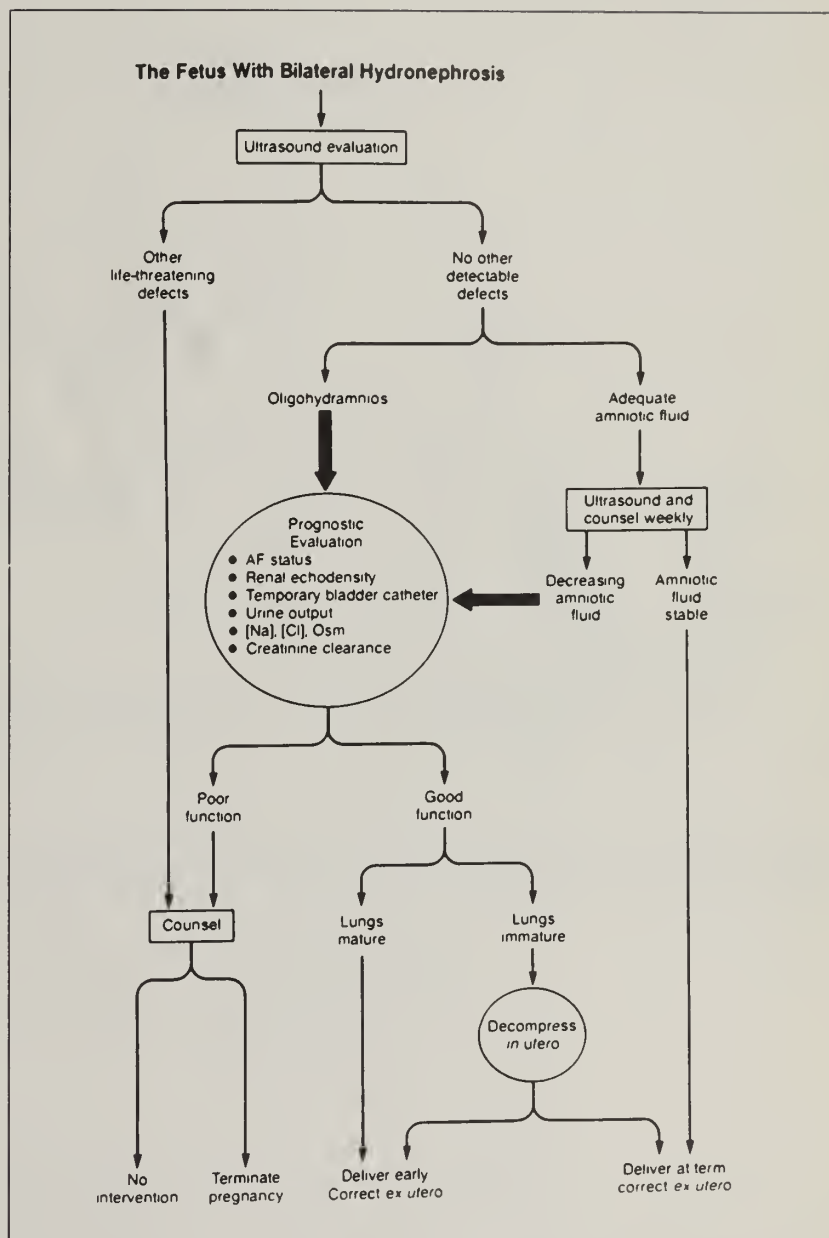


Fig 1—Management scheme for the fetus with bilateral hydronephrosis (With permission from Harrison MR, Adzick NS. The fetus as a patient: surgical considerations. *Ann Surg.* 1991;213:279-291.)

in utero correction versus *ex utero* treatment. Most impartial observers would take issue with the fact that there is no way, at present, to stratify congenital diaphragmatic hernia (ie, no sonographic or clinical characteristics guarantee an adverse outcome). In fact, all post partum attempts at classify-

Fetal Surgery

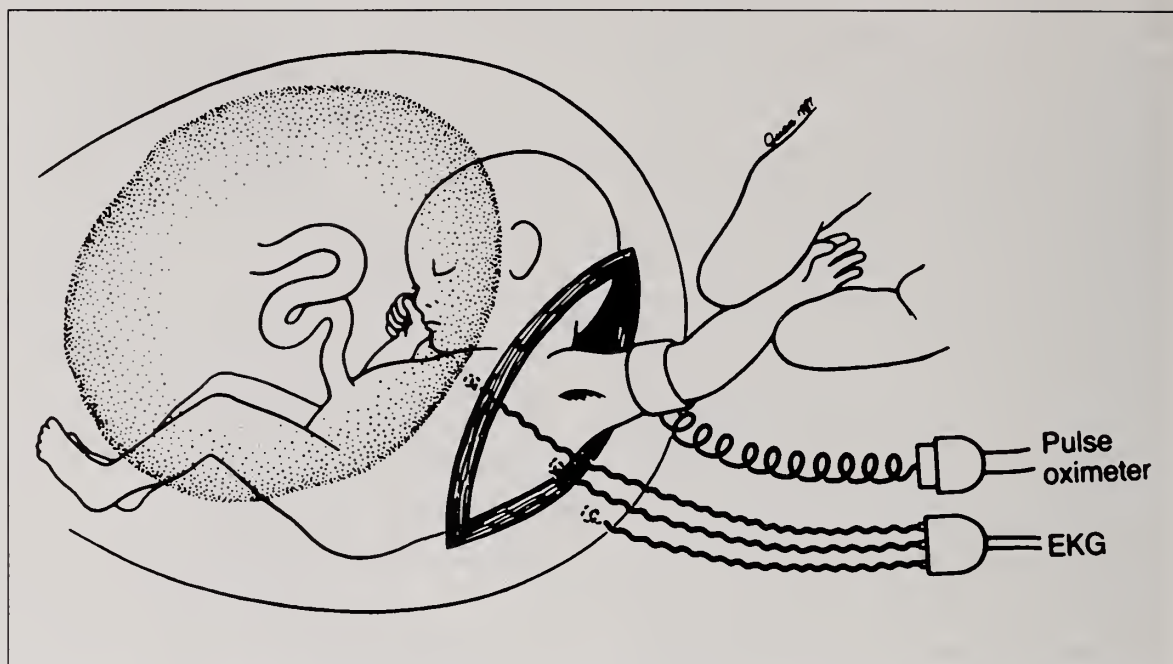


Fig 2—Left arm and chest exteriorized and monitors placed with subcostal incision shown. A miniaturized radiotelemetry device can be placed subcutaneously for perioperative fetal EKG, temperature, and activity monitoring. (With permission from Harrison MR, Adzick NS. The fetus as a patient: surgical considerations. *Ann Surg.* 1991;213:279-291.)

ing disease severity have not held up largely because of the ECMO salvage of conventional therapy failures. One is then left with a 25% survival for *in utero* correction versus a 60% survival for *ex utero* correction. Until criteria or investigational methods are developed to delineate those fetuses who will not survive despite ECMO capability, open repair of diaphragmatic hernia in the fetus does not seem warranted.

Fetal Hydrocephalus

The basis for the treatment of fetal hydrocephalus, like hydronephrosis, is that relief of obstruction will result in less end-organ damage; in this case, to the brain. Unfortunately, clinical trials in the early 1980s could not demonstrate any advantage. In 1986 Manning et al¹² reported the results

of an international fetal surgery registry in which 41 drainage procedures for obstructive hydrocephalus were performed from 1982 to 1985. Ventriculo-amniotic shunts were placed in fetuses at a mean gestational age of 27 weeks with 77% of the patients having aqueductal stenosis. Thirty-four patients survived (83%), with four procedure-related deaths. Eighteen of these (53%) patients had severe handicaps neurologically, with only twelve (35%) being neurologically normal. When one looks at the natural history of congenital hydrocephalus, survivorship following diagnosis and treatment *ex utero* is 80% to 90%, with a normal IQ in 60% to 70% (Table I).¹³ If diagnosed *in utero* and corrected after birth, survival decreases to 31%, with a normal IQ in 19%. Although *in utero* placement of ventriculo-amniotic shunts resulted in improved survival, neurologic impairment and procedure-related deaths led to a self-imposed moratorium of these procedures. These results underscore one important point: the fetal registry served its purpose by pooling data from these various institutions, which, in and of themselves, would not have come to these conclusions for many years. To date, fetal registries continue to be maintained and are discussed at annual fetal treatment meetings.

Table I. Congenital Hydrocephalus

	Ex Utero Diagnosis ¹³		In Utero Diagnosis ¹²	
	Untreated	Treated	Untreated	Treated
Survival (%)	20 to 23	80 to 90	31	83
Normal IQ (%)	38	60 to 70	19	35

Congenital Sacrococcygeal Teratoma

Sacrococcygeal teratoma (SCT) is a tumor arising from the coccyx, which, although formidable in appearance due to its large size, is usually benign in nature, easily resected, and results in a good long-term prognosis if recognized and treated early. Prenatal ultrasound diagnosis of SCT has revealed a "hidden mortality." Some fetuses with SCT die prior to birth. The mechanism for this has recently been documented.¹⁴

Serial ultrasounds of fetuses with large sacrococcygeal teratomas have shown hydrops and placentomegaly to be preterminal events. In a recently published series of 48 cases,¹⁴ hydrops and placentomegaly preceded fetal demise in 10 of these cases. It was proposed and concluded using Doppler examination of the umbilical artery, fetal aorta, and vessels within the tumor that there was shunting of blood away from the placenta and towards the tumor, which acted like a high flow arteriovenous malformation. This resulted in eventual heart failure with pleural and pericardial effusions. The only way to treat this condition would be to interrupt or decrease the blood supply to the tumor. To date, this has not been attempted. However, the natural history and outcome of this small subset of patients is clearly defined and an attenuation or interruption of flow is needed under these circumstances to ensure survival.

Maternal Outcome Following In Utero Surgery

The initial cause for alarm and restraint when open fetal surgery was first proposed revolved around the concern for maternal well being. The San Francisco experience¹⁵ has shown that after devoting a large amount of time and effort by obstetrical, anesthesiological, and surgical personnel to this formidable undertaking, open fetal surgery is safe and does not appear to have any harmful effects in subsequent pregnancies. The majority of prenatal operations have occurred during 21 to 26 weeks gestation, with the mothers being maintained on tocolytic agents until 33 to 34 weeks when lung maturation is guaranteed. Except for one episode of chorioamnionitis and pseudomembranous colitis, no other immediate complications have been reported. Eighteen patients have undergone open fetal surgery at University of California, San Francisco. Seven of these women have undergone subsequent pregnancy without complication.

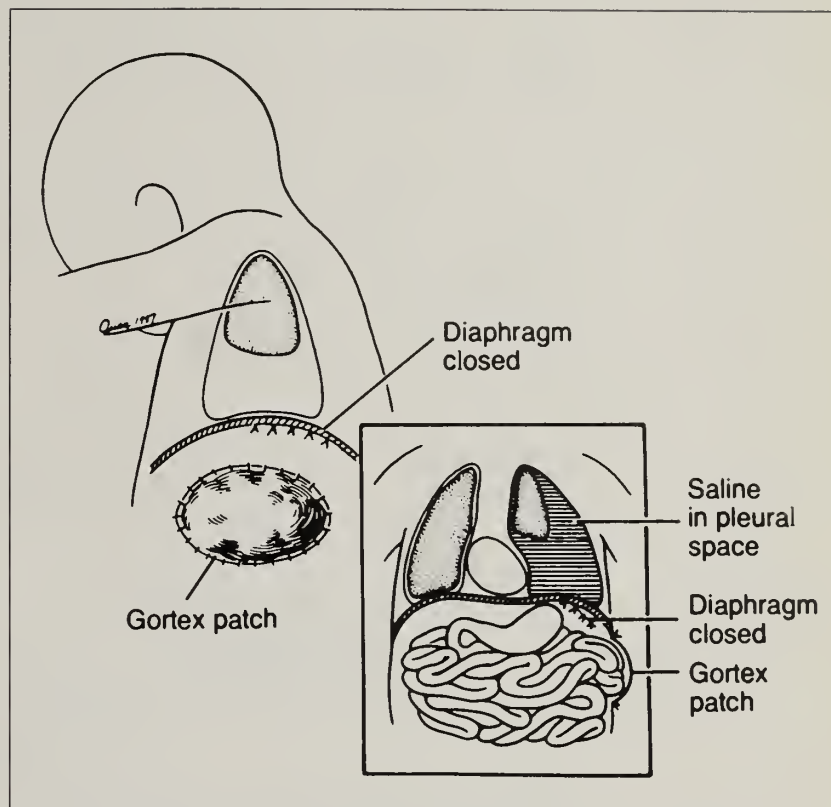


Fig 3—Diaphragm closed. Abdomen enlarged with patch to accommodate viscera without increasing intra-abdominal pressure. (With permission from Harrison MR, Adzick NS. *The fetus as a patient: surgical considerations.* Ann Surg. 1991;213:279-291.)

Correction of Constitutional Defects

Patients with hemoglobinopathies, such as thalassemia and sickle cell disease, are subjected to numerous hospitalizations, to the risk of transfusion-related diseases, growth retardation, and decreased life expectancies. Likewise, babies born with white cell dyscrasias are prone to infections and eventually require bone marrow transplantation for cure of their disease. Because chorionic villus sampling now allows us to diagnose certain blood dyscrasias at 11 to 13 weeks, is it possible to treat these diseases in early fetal stages?

The current status of bone marrow transplantation requires that space must be made in the recipient either by irradiation or chemotherapy to allow for the incoming donor marrow. There is a concomitant risk of bone marrow graft rejection, graft versus host disease, as well as the requirement for immunosuppression and possibility of opportunistic infections while waiting for engraftment to occur. All of these problems are

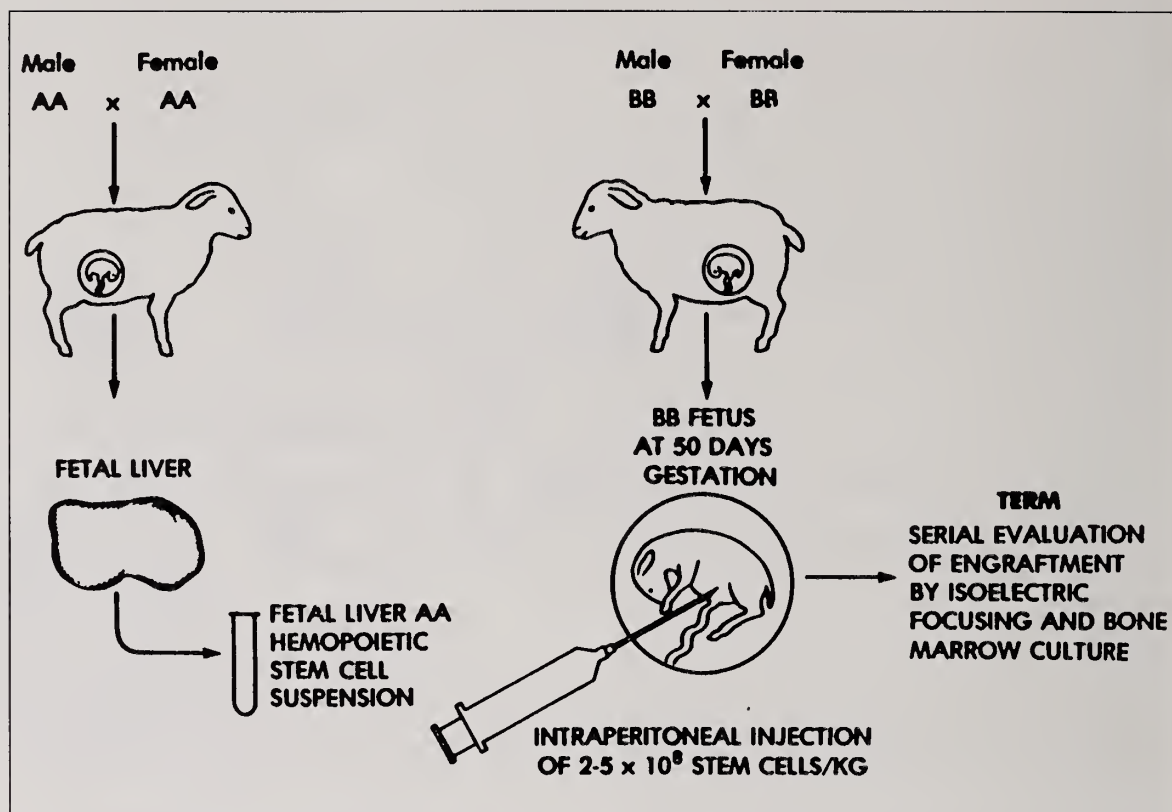


Fig 4—Schematic representation of sheep in utero stem cell transplantation model.

alleviated with a fetal host and recipient. Until about halfway through gestation in humans, immunocompetency has not been established. Since there is no immune response prior to mid-gestation, no immunosuppression would be required in these recipients and no graft versus host disease would result if both donor and recipient are immunoincompetent. In addition, the hematopoietic stem cells (pluripotent cells) are initially formed in the yolk sac, later moving to the liver, and then to the bone marrow in the human fetus from 8 to 18 weeks gestational age. Subsequently, the marrow is empty or partially filled prior to 18 weeks. Conceptually, if cells are delivered prior to this time, there would be adequate space in the marrow for them to engraft without any pre-conditioning regimen as required in conventional marrow transplantation.

This theory was first tested in fetal sheep, in which stem cells harvested from a 50-day-old fetal liver with Type A blood were given intraperitoneally to a similarly aged fetus with Type B blood.

It was found that engraftment occurred in three of four recipients with donor erythrocytes comprising 10% to 20% of the peripheral circulation and marrow¹⁶ (Fig 4). This was later reproduced in 60-day-old fetal rhesus monkey recipients. Because of the ability now to diagnose these diseases early in gestation, these results have profound implications in the treatment of hematopoietic dyscrasias in man. Conceivably, one could attempt to partially repopulate the affected fetus' bone marrow with donor cells from a normal fetus, which would then supply the deficient functions that the host cannot.

To date, there has been one patient with Hurler's syndrome who has received a stem cell transplant *in utero* (personal communication). Engraftment was successful in this patient. However, whether the engrafted cells will alleviate the long-term effects of Hurler's syndrome remains to be seen. If indeed successful, the implications are staggering and numerous discussions will unfold involving the ethical considerations in using fetal

tissue for such purposes. The National Institute of Health has currently placed a moratorium on such activities.

An approach, which obviates the use of donor fetal tissue, is that of *in utero* gene transfer. In this instance, circulating cells are removed from the fetal blood, a gene is inserted, and then the cells are given back to the fetus. This has been successfully done in sheep using a retroviral vector to introduce the gene.¹⁷ Concerns surround the efficacy and safety of retroviral vectors that randomly interpose their DNA message into host genome. These problems are currently being addressed at several centers that are looking for safer methods to introduce foreign DNA into cells.

Summary

When the concept of fetal surgery was originally proposed, it appeared that a great number of patients could eventually benefit from such therapy. However, with time, the risks and outcomes with congenital hydrocephalus seemed prohibitive, the indications and potential benefits for relieving congenital hydronephrosis decreased, and the efficacy of correcting congenital diaphragmatic hernia *in utero*, while feasible, was uncertain. These investigations have certainly not been in vain, however. We have learned much about the natural history of these diseases from experimental studies and clinical investigation and are now able to better treat these prenatally diagnosed problems.

Observations about fetal wound healing, which is distinct from adult healing, and, in some cases, is scarless, has led to a whole new field of investigation.¹⁸ The future of open fetal surgery, however, remains in doubt. Congenital diaphragmatic hernia appears to be the most likely defect to require antenatal correction, with the provision that adequate selection criteria can be established. Continued investigations are ongoing and we earnestly await the results of these. Meanwhile, the brightest future for fetal intervention rests in the correction of constitutional defects by stem cell transplantation and gene therapy.

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medical
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JULY 1990 VOL 15 / NO 7

Successfully defending a brain-damaged baby case is the courtroom equivalent of pitching a no-hitter. Because the "sympathy factor" can add millions to a jury's award, many insurance carriers would rather settle than fight.

Not so the P-I-E Mutual Insurance Co. of Cleveland, Ohio, and the 4-year-old law firm—Jacobson, Maynard, Tuschman & Kalur—that does all its defense work. In 21 brain-damaged baby cases it has defended for the doctor-owned company, its record is a remarkable 19-1-1, the last a hung jury. In 1988, its over-all record read 43 wins, 3 losses—all malpractice cases.

There's more to those numbers than luck. "We even legal-skill," adds JMT&K founding partner Aaron Jacobson, who was one of Ohio's leading plaintiff lawyers before he, Larry E. Rogers, Herbert S. Bell, M.D., and 70 other Cleveland doctors formed PIE in 1975.

"It's the concept behind the firm that makes it work. Physician specialty panels review every lawsuit to decide whether the defendant deviated significantly from the standard of care. If he did, we pay. If he didn't, we defend. Makes no difference whether it's a \$5,000 or a \$5 million case. We label it 'No pay.' That policy has resulted in a lot of cases being dropped. Perhaps more important, it's

DON'T YOU WISH THESE DEFENSE LAWYERS WERE YOURS?

This big, multistate firm rarely loses a case. But it's more than luck, or even legal skill, that's behind its enviable record.

By Howard Eisenberg

discouraged the filing of many other cases. Plaintiffs' attorneys have learned that we're fair negotiators when our doctor's in the wrong, but won't back down when he's right."

That approach pays off. According to the most recent report I've seen from the General Accounting Office, says Larry Rogers, PIE president and CEO, "in 1984, about 57 percent of medical malpractice claims were closed without payment. Through 1988, we've closed an average of 78 percent of our cases without a dime changing hands. And it's my understanding that, without including defense costs, St. Paul Fire and Marine Insurance Co.'s 1988 average gross payout for cases closed in Ohio with payment was \$32,500. Our comparable figure was about \$10,000 below

there. That's partly why we can sell an OBG specialist in Ohio—an industrial state that ranks among the most litigious—\$1.2 million in coverage for just \$26,400."

The unique marriage of PIE and JMT&K has been so successful that the carrier has expanded into five other states: Indiana, Kentucky, Maryland, Missouri, and West Virginia. Where PIE goes, there goes JMT&K, with nine branch offices to date. The firm has 40 trial attorneys, and may well be the nation's largest devoted well-nigh exclusively to medical malpractice defense.

Could the insurer-defender symbiosis, if duplicated by other doctor companies, make a significant contribution to reducing malpractice litigation nationwide? An up-close look at

how JMT&K operates may help to answer that question.

Every lawyer develops a medical specialty

"Our firm's lawyers read more medical books than law books," says PIE Vice President Gerard C. Oppenorth, himself a veteran defense attorney. Robert Maynard explains: "New cases are discussed at our weekly staff meeting, so that every lawyer is familiar with every case. But we assign cases to our attorneys according to medical specialty. They're well-versed in their fields, so they don't have to reinvent the wheel with each case."

Last year, the firm's OBG specialist, attorney Jerome S. Kalur, who had won 19 consecutive brain-damaged baby cases, faced one of his toughest challenges when he defended a GI

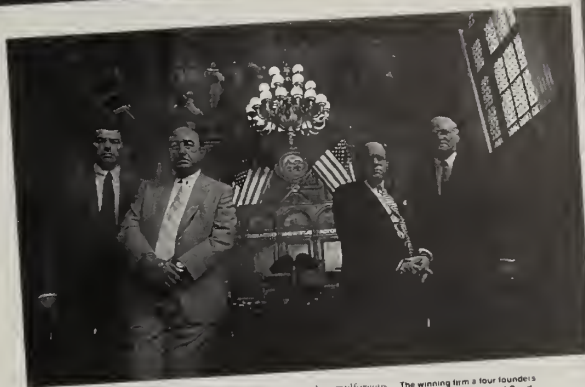
which attempted a midforceps delivery that ended in a C-section and a severely brain-injured baby. Recalls Kalur, "I didn't think the doctor had caused the damage, but our position was weakened by the fact that he didn't have midforceps privileges. Based on that departure from the standard of care, our doctor panel voted to settle, and, since the hospital was also involved, a combined sum of \$1.5 million was offered. Plaintiffs turned us down flat."

"I wanted to depose the doctors who'd been involved in the mother's care during her hospitalization, but the attorney for the plaintiff baby insisted it would violate the mother's physician-patient confidentiality. That privilege would terminate automatically when her medical

The winning firm, a four-founder at Cleveland's 8th District Court of Appeals (from left): Jerome S. Kalur, Aaron Jacobson, James M. Tuschman, and Robert Maynard.

records were introduced at the trial end of the plaintiff's case. Meanwhile, I was in the main position of having to tell the jury, 'It couldn't have been the midforceps—without offering them another reasonable brain-damage theory.'"

Fortunately, the plaintiffs rested their case on a Friday afternoon, giving JMT&K time for a weekend rally. "Twenty minutes later," says Kalur, "I was in the hospital pathologist's office with an order permitting me to view the mother's placental slides. Meconium staining had been charted, and Kalur had a hunch that fetal distress had begun long before the for-



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MAY

16 — Management of Retinal Vascular and Macular Disorders; Radisson Plaza Hotel, Lexington, KY. Course Directors: William Wood, MD, and Rich Isernhagen, MD. Contact: Kay Montgomery, The Center for Advanced Eye Surgery at Humana Hospital-Lexington at 606/268-3754.

17-22 — 23rd Family Medicine Review, Session II; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

JUNE

1-3 — 60th Assembly of the Southeastern Surgical Congress, Presentations and posters should be submitted by November 15, 1992. Contact: Roger Sherman, MD, Secretary Director of the Southeastern Surgical Congress, 69 Butler St Southeast, #314, Atlanta, GA 30303.

11-13 — 37th Great Smoky Mountains Pediatric Seminar; Park Vista Hotel, Gatlinburg, TN. Contact: Continuing Medical Education, 1924 Alcoa Highway, D-116, Knoxville, TN 37920; 615/544-9190.

AUGUST

8-14 — 11th Annual Scientific Meeting and Exhibition of the Society of Magnetic Resonance in Medicine; Berlin, Germany. Contact: SMRM, 1918 University Avenue, Suite 3C, Berkeley, CA 94704; 510/841-1899; FAX 510/841-2340.

SEPTEMBER

3-5 — Perinatal Medicine; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

25-26 — 5th Annual Rehabilitation Management for the Primary Care Physician; Radisson Plaza Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME,

Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

OCTOBER

25-30 — 23rd Family Medicine Review, Session III; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

NOVEMBER

8-12 — 96th Annual Meeting of The American Academy of Ophthalmology; Dallas Convention Center. Contact: The American Academy of Ophthalmology, Meetings Dept, PO Box 7424, San Francisco, CA 94120-7424; 415/561-8500.

12-15 — Southern Medical Association's 86th Annual Scientific Assembly; San Antonio, TX. Contact: SMA's Member Services Center; 800/423-4992; or 205/945-1840.

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The US Virgin Islands is a very small medical society. There are only two CME sponsors, the St. Croix Hospital and the St. Thomas Hospital. Both hospitals have very well-organized, active CME Committees. They need qualified speakers for CME programs. However, since they are such a small society, it is not possible for them to offer a stipend, travel expenses, or lodging.

If you will be vacationing there and are interested in giving a CME lecture, please call the St. Croix Hospital Staff CME Director, Dr Angelo Galiber at 809/778-5305; Dr Brian Cheetham, the St. Thomas Hospital CME Chairman at 809/774-1080; or Dr Francis J. Farrell, Chairman, VIMS Accreditation Committee, at St. Croix 809/778-6400 or St. Thomas 809/776-0506.

SUE!

In November 1991 the *Journal* won first place for Excellence of Design and Printing in the nationwide journal competition of the American Medical Writers Association. We and, I hope, you are button-popping proud of this award.

What is the American Medical Writers Association? It is a collection of some 3,000 writers who are engaged professionally or by interest in describing and communicating the research and accomplishments of medical scientists to each other and to the large public who is affected personally and intellectually by these sciences. These writers are intensely active in improving the quality and effectiveness of scientific medical communication for themselves and all the members of their young profession. Founded in 1940 by physician editors, the organization has grown slowly and healthily into an institution of teaching and learning of wonderfully easy access which at first bypassed and now is infecting universities.

Why did the *Journal of the Kentucky Medical Association* receive this meaningful award? Sharp, Mrs D. Sue! The talented and dedicated managing editor of the *Journal* has accomplished what hired design artists could not. With energetic attention to detail as well as presentation, she has achieved a dynamic print format of clean, modern design which amplifies the messages of Kentucky's contributing authors and the Kentucky Medical Association. Of her we are proud.

A. Evan Overstreet, MD
Editor

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PHYSICIAN — STUDENT HEALTH SERVICES — Eastern Kentucky University. Physician for a university health clinic at a regional university, with an enrollment of over 16,500 students. Physician must have medical license in Kentucky. Specialty in family practice or internal medicine preferred. Position begins July 1, or August 15, 1992, and will be a 12-month appointment thereafter. Competitive salary with excellent benefits. Contact: Vice President for Student Affairs, Box 32A Coates Administration Building, Eastern Kentucky University, Richmond, KY 40475. Application deadline: June 1, 1992. *Employment eligibility verification required, Immigration Reform and Control Act of 1986.* AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

PHYSICIAN OPPORTUNITY

The Department of Orthopaedics and Rehabilitation and the Ability Assessment Center of Vanderbilt University Medical Center have an immediate opening for a physician who is interested in musculoskeletal disorders and occupational medicine. The successful applicant must have a MD degree and a valid Tennessee medical license. Additional training in one of the following specialties would be desirable: Internal Medicine, Family Practice, Occupational Medicine, Physical Medicine, Rheumatology. In addition to patient care opportunities, involvement in clinical research and administrative responsibilities are possible. Please send curriculum vitae and three references to:

Dan Spengler, MD
Professor and Chairman
Department of Orthopaedics and
Rehabilitation
Vanderbilt University Medical Center
D-4219
Nashville, TN 37232-2550

What is your specialty?

Doctor of Medicine (MD)
 Doctor of Osteopathy (DO)



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Kentucky Air National Guard
(502) 364-9424 (call collect)



Breaking the Cycle of Violence

"The AMA Auxiliary has launched a three-part program that includes educating the public, supporting victims, and providing physicians with resources for their patients who are victims of family violence."

Domestic violence touches as many as one-fourth of all American families.

Three siblings in 100 use weapons on a sister or brother, meaning that 100,000 children in the United States annually face a brother or sister with a gun or knife in hand.

Six of 10 couples have experienced violence at some time during their marriages, with either husbands beating wives, or wives beating husbands.

Approximately 900,000 parents are beaten or abused by their children each year.

Child homicide is now among the five leading causes of death in childhood, with the majority of infant victims killed by parents, relatives, and older children.

More than 1 million — 4% of older Americans are physically and emotionally abused by their relatives.

Experts agree that interpersonal violence, like charity, begins at home. But when violent behavior has been ingrained from cradle to grave and repeated from one generation to the next, can the cycle be broken?

Across the country, hundreds of prevention programs, big and small, are answering that question "yes."

At the core of these primary prevention efforts is the belief that violence can be unlearned or not taught in the first place. Programs in health clinics, churches, schools, workplaces, theaters, and community centers around the country are using techniques such as social skills training, stress management, conflict resolutions, role modeling, surrogate parenting, and motivation and self-esteem building to help build a climate that rejects violence and encourages alternatives to resolving disputes.

In an effort to promote medical community involvement, the American Medical Association has launched a nationwide effort to involve physicians in preventing family violence and providing help for victims of child physical and sexual abuse, elder abuse, and spouse abuse. The AMA is asking physicians to become members of the National Coalition of Physicians Against Violence, and to work with other concerned groups and individuals to develop local Family Violence Prevention Committees that can set agendas to combat the problem. This new coalition will also serve as a source of information for physicians,

providing them with newly updated guidelines on child physical and sexual abuse, domestic violence, and elder abuse.

In response to the AMA's request, the AMA Auxiliary has launched a three-part program that includes educating the public, supporting victims, and providing physicians with resources for their patients who are victims of family violence. We, as auxiliary members, are also invited to join the National Coalition of Physicians Against Violence and to work with physicians to develop local Family Violence Prevention Committees in our communities. We are in a unique position to help with this project.

I challenge each of you to do a little investigative research when you return home. Is there a spouse abuse and/or child abuse center in your area? If so, talk to the director of that facility. Find out what the situation is in your area. What kind of help do they most need? Financial? Or volunteers?

Is there a program in your local hospital? Has the emergency room staff been trained to recognize the signs of battering? Domestic violence is the single largest cause of injury to women in the United States — more common than automobile accidents, muggings, and rapes combined. The FBI estimates that a woman is beaten every 15-18 seconds in this country. Violence affects women of all social groups, ages, races, rural and urban environments, and affects both rich and poor and both heterosexual and lesbian women. Battered women regularly call upon the health system. Studies have shown that abused women have more health problems than non-abused women, so those who trust the health system and have insurance probably seek health care at disproportionately high rates. Studies have also shown that 22% to 35% of all women who use emergency room services are battered women, and because the same

women may need to return time and time again, almost half of all injuries presented by women in emergency rooms may be due to abuse. Many battered women would like to tell someone about the violence in their lives and would greatly benefit from knowing that their situation is not unusual and that there are a range of excellent resources available to them. Experts on family violence agree that physicians should routinely ask women patients about possible abuse. Many suggest that such questions should be asked in a matter-of-fact, non-judgemental way even if the patient shows no signs of having been abused. Understanding common patterns of domestic violence makes it obvious that health workers who do recognize battered women and empower them to explore their options can play a key role in helping women end the violence in their lives.

Before talking to your physician spouses or your hospital

administrators, I encourage you to do your homework. Hospitals, like physicians, are being besieged on many fronts. They will react negatively if approached in a confrontational way with little factual support. Remember, we want to be part of the solution, not part of the problem.

In closing, I'd like to paraphrase a comment made by Sarah Weddington, a Texas attorney who spoke to us at Confluence.

Ordinary people sometimes do extraordinary things. There are ways in which we are all very ordinary and yet in other ways we are very special. We may never get the whole world straightened out, but we can and are working today for a better tomorrow.

Beryl Dodds

AKMA President



Medical Challenges In An Age Of Risk

KMA Annual Meeting • Sept 13-17 • Hyatt Regency
Commonwealth Convention Center • Louisville, KY

A New Prescription for Kentucky's Indigent Health Care

Due to the generosity of Pfizer/Roerig Pharmaceuticals and the G. D. Searle Company, thousands of low income Kentuckians are receiving free prescriptions and pharmacy services through the Kentucky Pharmacy Providers program which was launched in July 1990.

An agreement between the Kentucky Health Care Access Foundation, the Kentucky Pharmacists Association, Pfizer/Roerig Pharmaceuticals, and the G. D. Searle Company makes Pfizer Labs/Roerig and Searle's entire line of prescription drug products available to Kentucky Physicians Care patients at no charge.

In extending this access to prescription drugs, Pfizer/Roerig and Searle are making their products available at **no cost** and participating pharmacists are dispensing them **without charge** to eligible ambulatory patients.

Only prescriptions written for Pfizer/Roerig or Searle products for KPC eligible patients by KPC participating doctors will be filled through the Kentucky Pharmacy Providers program.

If you have questions, or for those physicians not currently participating in KPC who wish to participate, please contact the KPC referral office — **1-800-633-8100** or the KMA Headquarters Office — **1-502-459-6200**.

**PLEASE REFER TO THE FOLLOWING PAGES
FOR A LIST OF AVAILABLE
PFIZER/ROERIG AND SEARLE PRODUCTS
AND A LIST OF PARTICIPATING PHARMACIES**

PHARMACEUTICALS AVAILABLE TO KENTUCKY PHYSICIANS CARE

These Pfizer/Roerig & Searle pharmaceuticals may be prescribed and dispensed under the program:

Pfizer Labs

Antiminth® (Pyrantel pamoate) OTC
 Cortril® Topical Ointment 1% (Hydrocortisone) Rx
 Diobinese® Tablets (Chlorpropomide) Rx
 Diobinese® Tablets Unit-Dose Pak (Chlorpropomide) Rx
 Feldene® Capsules (Piroxicam) Rx
 Feldene® Capsules Unit-Dose Pak (Piroxicam) Rx
 Minipress® Capsules (Prozolin HCl) Rx
 Minipress® Capsules Unit-Dose Pak (Prazosin) Rx
 Minizide® 1 Capsules (1 mg. Prazosin and 0.5 mg. Polythiazide) Rx
 Minizide® 2 Capsules (2 mg. Prazosin and 0.5 mg. Polythiazide) Rx
 Minizide® 5 Capsules (5 mg. Prazosin and 0.5 mg. Polythiazide) Rx
 Moderil® Tablets (Rescinnamine) Rx
 Procordio® Capsules (Nifedipine) Rx
 Procordio® Capsules Unit-Dose Pak (Nifedipine) Rx
 Procordia XL® (Nifedipine) Extended Release Tablets Rx
 Procordio XL® (Nifedipine) Extended Release Tablets Unit-Dose Pak Rx

Renese® Tablets (Polythiazide) Rx
 Renese®-R Tablets (2 mg. Polythiazide and 0.25 mg. Reserpine) Rx
 Sustaire® (Theophylline anhydrous) Rx
 Terramycin® Capsules (Oxytetracycline HCl) Rx
 Vansil® Capsules (Oxamniquine) Rx
 Vibra-Tabs® (Doxycycline hyclate) Rx
 Vibra-Tabs® Unit-Dose Pak (Doxycycline hyclate) Rx
 Vibramycin® Calcium Syrup (Doxycycline calcium oral suspension) Rx
 Vibramycin® Hyclate Capsules (Doxycycline hyclate) Rx
 Vibromycin® Hyclate Capsules Unit-Dose Pak (Doxycycline hyclate) Rx
 Vibramycin® Manahydrate for Oral Suspension (Doxycycline manahydrate) Rx
 Vistaril® Capsules (Hydrazine pamoate) Rx
 Vistaril® Capsules Unit-Dose Pak (Hydrazine pamoate) Rx
 Vistoril® Oral Suspension (Hydrazine pamoate) Rx
 Zithromax® Capsules (Azithromycin)

Roerig

Antivert® (Meclizine HCl) Rx
 Antivert® Tablets Unit-Dose Pak (Meclizine HCl) Rx
 Atorox® (Hydrazine HCl) Rx
 Atorox® Tablets Unit-Dose Pak (Hydrazine HCl) Rx
 Banine® Chewable Tablets (Meclizine HCl) OTC
 Cefabid® (Cefaperazone sodium) Rx
 Diflucan® (Fluconazole) Oral and Parenteral Antifungal Rx
 Diflucan® (Fluconazole) Unit-Dose Pak Oral and Parenteral Antifungal Rx
 Emete-con® IM/IV (Benzquinamide HCl) Rx
 Geocillin® (Carbenicillin indanyl sodium) equivalent to 382 mg. carbenicillin Rx
 Geopen IM/IV (Carbenicillin disodium) Rx
 Glucotrol® Tablets (Glipizide) Rx
 Glucotrol® Tablets Unit-Dose Pak (Glipizide) Rx
 Heptuna® Plus Capsules (Iron plus vitamins and minerals) Rx
 Hydracortisane Powder (Hydrocortisone USP micronized) Rx
 Isoject® Permapen® (Penicillin G benzathine) Aqueous Suspension Rx
 Morax® (Hydrazine HCl [ATARAX®]-Theophylline-ephedrine sulfate) Rx
 Navane® Capsules (Thiathixene) Rx
 Novone® Capsules Unit-Dose Pak (Thiathixene) Rx
 Novone® Concentrate (Thiathixene HCl) Rx
 Novone® Intramuscular (Thiathixene HCl) Rx
 Pfizerpen® for Injection (Penicillin G potassium) Buffered Rx

Pfizerpen®-AS (Penicillin G procaine) Aqueous Suspension Rx
 Polymyxin B Sulfate Sterile Rx
 Sinequan® Capsules (Doxepin HCl) Rx
 Sinequan® Capsules Unit-Dose Pak (Doxepin HCl) Rx
 Sinequan® Capsules Unit of Use Pak (Doxepin HCl) Rx
 Sinequan® Oral Concentrate (Doxepin HCl) Rx
 Spectrabid® Oral Suspension (Bacampicillin HCl) Rx
 Spectrabid® Tablets (Bacampicillin HCl) Rx
 Streptomycin Sulfate Rx
 Too® Capsules (Troleandomycin) Rx
 Terro-Cortril® Ophthalmic Suspension (Oxytetracycline HCl and hydrocortisone acetate) Rx
 Terramycin® Intramuscular Solution (Oxytetracycline) Rx
 Terramycin® Ophthalmic Ointment with Polymyxin B Sulfate (Oxytetracycline HCl with polymyxin B sulfate) Rx
 Terramycin® Vaginal Tablets with Polymyxin B Sulfate (Oxytetracycline HCl with polymyxin B sulfate) Rx
 Unosyn® (Ampicillin sodium/sulbactam sodium) Rx
 Urobatic® 250 (250 mg. Oxytetracycline HCl 250 mg. sulfamethizole 50 mg. phenazopyridine HCl) Rx
 Vibramycin® Intravenous (Doxycycline hyclate for injection) Rx
 Vistaril® Intramuscular Solution (Hydrazine HCl) Rx
 Vistaril® Intramuscular Solution Unit-Dose Vials (Hydrazine HCl) Rx

Roerig & Pratt Division

Zalafi® Tablets (Sertraline)

Searle

Aldactone® tablets (spironolactone with hydrochlorothiazide)
 Aldactone® tablets (spironolactone)
 Calan® SR caplets (verapamil HCl)
 Colon® caplets (verapamil HCl)
 Cytotec® tablets (misoprostol)

Kerlane® tablets (betoxalal HCl)
 Nitradisc® discs (nitroglycerin)
 Norpoce® capsules (disopyramide phosphate)
 Norpoce® CR capsules (disopyramide phosphate)

PARTICIPATING PHARMACIES

KPC PHARMACY PROVIDER PROGRAM

Adair
DBA Columbia Pharmacy
Madison Square Drugs & Chymist

Allen
Carpenter Dent Drugs
Stavall Prescription Shop
Williams Pharmacy

Anderson
The Medicine Shoppe
Reliable Drugs

Borren
Ely Drugs, Inc.
Glasgow Prescription Center
Tawne & Country Drugs

Bell
City & County Drug
Farris Drugs
Jeff's Pharmacy
Kroger Company
Pineville Has. Out-Pt Pharmacy
SuperX Drugs
Total It Care Pharmacy

Boone
Boone County Drugs
Burlington Pharmacy
SuperX Drugs
Turfway Pharmacy

Bourbon
Glen's Drugs
Horne's Ardrey Drug
The Medicine Shoppe

Boyd
McMeans Pharmacy
Reliable Drugs
SuperX Drugs

Boyle
Grider Pharmacy
Leake Pharmacy
SuperX Drugs
Taylor Drug

Brocken
Dean's Pharmacy

Breothitt
Jackson Prescription Ctr
Reliable Drugs

Breckinridge
Save-Rite Drugs
Tawne & Country Pharmacy

Bullitt
Taylor Drugs

Caldwell
Payless Discount Pharmacy
The Pharmacy Corner Enterprise

Calloway
Clinic Pharmacy
Halland Drugs
Reliable Drugs
Safe-T Discount Pharmacy
Walter's Pharmacy

Campbell
Alexandria Drugs
Martin's Pharmacy
Newport Drug Center
SuperX Drugs

Corroll
Parklane Pharmacy
Webster Drugs

Cortier
Hartan Brather & Brawn
Rase Pharmacy

Christion
Express Pharmacy
Horn Prescription Shop
Jennie Stuart Medical Center
Reliable Drugs
Save More Drug
The Medicine Shoppe

Clark
Carner Drug Store
Day Drugs
Reliable Drugs
SuperX Drugs

Cloy
Family Drug Center
H & N Drug
Medi Center Drugs

Crittenden
Glenn's Apothecary

Cumberland
Smith Pharmacy

Doviess
Danahauer Drug Company
Emery Centre Pharmacy
Greene's Pharmacy
Harrel's Drug Store
Mayfair Pharmacy
Medical Plaza Pharmacy
Medicine Shoppe
Nation's Medicines
Reliable Drugs
Taylor Drug #21
Wal-Mart Pharmacy

Edmonson
Prescription Shop

Foyette
Hi-Acres Pharmacy
Hubbard & Curry Pharmacy
Hutchinson Drug
All Kroger Pharmacies
Professional Arts Apothecary
Randall's Pharmacy
Taylor Drugs
The Medicine Shoppe
Warehouse Drugs
Woodhill Pharmacy

Fleming
Plaza Pharmacy

Floyd
Archer Clinic Pharmacy
Betsy Layne Pharmacy
Mud Creek Clinic Pharmacy
Our Lady Of The Way Hospital

Franklin
East Side Pharmacy
Fitzgerald Drugs
Kroger Pharmacy
Medicine Shoppe
Reliable Drugs
Taylor Drugs
The Prescription Center

Fulton
City Super Drug
Evans Drug Company
Rumfelt Drug
SuperX Drugs

Gorrod
Sutton Pharmacy

Grant
Grant County Drugs

Groves
Stanes Drugs
SuperX Drugs
Wilson Rexall Drugs

Groyson
Clarkson Drug Store
Reliable Drugs

Green
Model Drug Store

Greenup
Reliable Drugs
Scott Drugs
Stultz Pharmacy

Hordin
Jeff's Prescription Shop
Kroger Company
Showers & Hays Drugs
SuperX Drugs
Taylor Drugs

Horlon
Lynch Med. Services Pharmacy
SuperX Drugs

Harrison
Eastside Pharmacy Of Cynthia
Lee Drugs

Hort
Branstetter Pharmacy
Clarks
Mallory Drugs

Henderson
Dunaway's Imperial Pharmacy
Reliable Drugs
T & T Drugs

Henry
Cook's Pharmacy

Hopkins
Earlington Pharmacy
Family Drugs
Madisonville Pharmacy
Nation's Medicines
Professional Drugs #2
Reliable Drugs
SuperX Drugs

Jackson
Annville Pharmacy
Clinic Pharmacy

Jefferson
Alliant Health System Pharmacy
Art Jacob Prescription Shoppe
Colonial Drugs
Cox's Pharmacy
DBA Hametek Pharmacy
Harding Pharmacy
Haldaway Drugs
Hume Pharmacy
Koby Drug Company
All Kroger Pharmacies
Oak Drug Company, #1
Rauben's Pharmacy
St. Denis All Care
All SuperX Drugs
All Taylor Drugs
Union Prescription Center
Wal-Mart Pharmacies
Warehouse Drugs

Jessamine
Drug Mart
Medicine Shoppe
Taylor Drugs

Johnson
Bi-Rite Pharmacy
Reliable Drugs

Kenton
Blank's Pharmacy
Boeckley Drugs
Cherokee Drug Shoppe
Crestville Drugs
Farrell Pharmacy
Fort Mitchell Drug Shoppe
Fort Mitchell Pharmacy
Ludlow Drugs
Medical Village Pharmacy
Marwessel Drugs
Nie's Independence Pharmacy
Save Discount Drugs
All SuperX Drugs

Knox
Knox Professional Pharmacy
Sav-Rite Pharmacy

Laurel
Family Drugs
Kelley's Medical Arts Pharmacy
Laurel Heights Nursing Home
Landon City Drug Co.
Landon-Corbin Pharmacy
SuperX Drugs

Lee
Stufflebean Pharmacy
Three Forks Apothecary

PARTICIPATING PHARMACIES KPC PHARMACY PROVIDER PROGRAM

<p>Letcher Porkway Pharmacy Shapwise Pharmacy</p> <p>Lincoln Caleman's Drug Store Rishie Drugs</p> <p>Livingston Glenn's Prescription Center</p> <p>Logan Gower Drug Store Riley-White Drugs Wal-Mart Pharmacy</p> <p>Madison Berea Hospital Out-Patient Kraeger Company SuperX Drugs</p> <p>Mogoffin Clinic Pharmacy</p> <p>Marion Hagan-O'Daniel Pharmacy Pat's Pharmacy Reliable Drugs Southall Pharmacy</p> <p>Marshall Bentan Discount Pharmacy Draffenville Pharmacy J & R Pharmacy Nelson VoluRite Pharmacy Pay-N-Save Discount Drugs</p> <p>Moson Medical Arts Pharmacy Reliable Drugs Tancray Martor & Pestle Kentucky Med KPC Program sondy kenad\$\$\$1204-17-92 08:26:42</p> <p>McCracken Davis Drugs Katterjohn Drug Store Kraeger SuperX Drugs The Medicine Shoppe</p> <p>McCreary Burgess Drug Store Daugherty Drugs</p>	<p>Meode Riverview Pharmacy</p> <p>Mercer Kraeger Company SuperX Drugs</p> <p>Metcalfe Metcalfe Drugs Nunn Drugs</p> <p>Montgomery Calica & Whitt Drug Emil W. Baker, Pharmacist Ross Drugs SuperX Drugs</p> <p>Muhlenberg Beechmant Pharmacy Clinic Pharmacy Reliable Drugs</p> <p>Nelson Reliable Drugs</p> <p>Nicholas Carlisle Drug</p> <p>Ohio L. L. Bane Pharmacy Reliable Drugs Rice Drug Store</p> <p>Oldhom Taylor Drugs</p> <p>Owsley Owsley Prescription Center</p> <p>Pendleton Moreland Drug</p> <p>Perry L. B. Clinic Pharmacy Reliable Drugs SuperX Drugs Vicca Pharmacy</p> <p>Pike Medical Pharmacy Nichals Apathecery SuperX Drugs</p>	<p>Puloski Brawn's Bagle Street Pharmacy Kraeger Company Reliable Drugs Somerset Pharmacy SuperX Drugs The Medicine Shoppe Tibbals Drug Store Wal-Mart Pharmacy</p> <p>Rockcastle Mt. Vernon Drive-Thru Yaughs Pharmacy</p> <p>Rowan Cove Run Pharmacy Reliable Drugs</p> <p>Russell Daugherty Pharmacy Happer Drug</p> <p>Scott Dactar's Park Pharmacy Fitch Drug Store Kraeger Company Reliable Drugs</p> <p>Shelby Reliable Drugs Smith-McKenney</p> <p>Simpson Arnold Drug Company Prescription Shop R. H. Moore Drug Company Reliable Drugs Shugart & Willis</p> <p>Spencer W. T. Framan Drug Company</p> <p>Taylor Central Drug Center Kraeger Company SuperX Drugs The Medicine Shoppe</p> <p>Todd Weathers Drugs</p> <p>Trigg Save On Drugs</p>	<p>Union Clements Drug Carner Drug Store Professional Drugs #1 Reliable Drugs Sturgis Pharmacy</p> <p>Warren Ashley Circle Pharmacy C. D. S. #10 Drug Clinic Pharmacy Medicine Shoppe Northgate Pharmacy Reliable Drugs SuperX Drugs Taylor Drugs Williams Drug Company</p> <p>Washington County Drug</p> <p>Wayne Daffron Drug F & H Drug Plaza Drugs</p> <p>Webster Providence Pharmacy Thrifty Pharmacy, Inc.</p> <p>Whitley Cottongim Drug Company Doctors Park Apathecery</p> <p>Wolfe Compton Discount Drugs</p> <p>Woodford Carner Drug at Versailles Midway Drug SuperX Drugs Taylor Drugs</p>
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PEOPLE

In June 1991, the University of Kentucky Medical Alumni Association Board established the Distinguished Alumnus, Alumni Service, and Honorary Alumnus Awards in recognition of distinguished persons associated with the UK College of Medicine. Included among the *first* recipients of these awards were several KMA members. Their awards and Alumni Board profiles are shown below.

Alumni Service Award—*A graduate of the UK College of Medicine or a former resident at the Medical Center who has performed volunteer actions and/or services that greatly advanced the goals of the College or the profession.*

Preston P. Nunnelley, MD, (1970)
Alumni Service Award, 1991-92

Preston P. Nunnelley, a native of Mt. Vernon, KY, entered a private partnership practice of obstetrics and gynecology in Lexington in 1974 and remains in that practice today. He is a fellow of the American College of Obstetrics and Gynecology.

In 1976 he was named a UK Development Council member and served in that capacity until 1982 when he was named the Chairman of the Medical Center Development Council, a position he still holds today. He became a UK fellow in 1975. In 1980 he served as chairman of the 1970 Class 10th Anniversary Gift Program and helped establish an anniversary gift record that remained unchallenged for almost a decade. As part of that class gift program, his wife, Lucille Nunnelley, also became a UK fellow.

He has served as president of the Fayette County Medical Society and as president of the Kentucky Medical Association in 1991. He founded the Fayette County Indigent Prenatal Clinic at the Fayette County Health

Department and served as its director from 1983 to 1987. He has served on many other professional and civic organizations.

He was given the Distinguished Alumni Award in 1989 by Eastern Kentucky University and was named to the UK Hall of Distinguished Alumni that same year.

The Board of the UK Medical Alumni Association recognizes his service to both his college and his profession in making this award.

Honorary Alumnus Awards—*An individual who is not an alumnus but who has present or prior association with the College and who has performed dedicated and distinguished service which has made him or her a notable and important part of the College. This award may be given posthumously. (All of the 1991-92 awards were given posthumously.)*

John S. Chambers, MD
1889-1971

In 1928 Dr Chambers, head of the Department of Hygiene and Public Health at the University of Kentucky, was asked by then President, Dr Frank McVey, to make a study of the need for medical education in the state. This request resulted in a document entitled "Medical Education in Kentucky" printed in 1953 in which Dr Chambers outlined the need for additional physicians and a new medical school in Kentucky. This study was influential in the approval of the establishment of the University of Kentucky Medical Center by the Board of Trustees on June 1, 1954, and approved by the General Assembly in 1956. He was a member of the Kentucky Medical Education Foundation which used the data from his "Medical Education in Kentucky" study to build support for the establishment of the Medical Center.

Coleman C. Johnston, MD
1906-1983

Under the leadership of Dr Johnston, a Lexington surgeon, who served as President of the Fayette County Medical Society in the late 1940s, the Kentucky Medical Education Foundation was established. This foundation worked for several years to build support for the establishment of the University of Kentucky Medical Center.

Francis Massie, MD
1894-1985

Dr Massie, a leading surgeon in Lexington, was a member of the Kentucky Medical Education Foundation which was influential in the establishment of the University of Kentucky Medical Center.

Edward H. Ray, Sr, MD
1899-1987

Dr Ray, a Lexington urologist, was also a member of the Kentucky Medical Education Foundation which was influential in the establishment of the University of Kentucky Medical Center.

The Distinguished Alumnus Award went to a Lexington native, Rice Leach, MD (1966), who was appointed Chief of Staff to the Surgeon General on April 12, 1990.

Stand-up comedian Clifford Kuhn, aka **Clifford C. Kuhn, MD**, met the press dozens of times during a 6-month sabbatical from his job as a University of Louisville psychiatry professor.

In October, *Newsweek* devoted an entire page to Dr Kuhn's studies on the healing effects of laughter. Other stories about Dr Kuhn appeared on National Public Radio, "Entertainment Tonight," the "Deborah Norville Show," radio

stations in Los Angeles, St. Louis, Boston, Chicago, and "Newsweek on Air," a program that goes to 110 radio stations plus the US Armed Forces Network.

Patricia M. Quinby, MD,

University of Louisville Department of Family Practice, presented two papers at the Predoctoral Education Conference in St. Petersburg, Florida. The two papers were: "The Development and Testing of an OCE for a Junior Clerkship in Family Medicine" and "National Survey of American Association of State Chapters Regarding Their Activities to Attract Medical Students to Family Practice Careers."

UPDATES

UK College of Medicine Ranked 7th in Nation in Survey by U.S. News and World Report

The University of Kentucky College of Medicine has the seventh-best comprehensive medical school in the nation, according to an annual survey released by *U.S. News and World Report* magazine. In its March 23 issue, the magazine ranked the top 10 medical schools with comprehensive education programs. UK ranked 7th with 92.5 points out of a possible 100. Thomas Jefferson University in Philadelphia and Brown University in Providence, Rhode Island, tied for the number one position.

"We're pleased with this recognition," said **Dr Emery Wilson**, dean of the College of Medicine. "Coming in the wake of a major curriculum grant award by the Robert Wood Johnson Foundation, it reinforces our belief that we have an outstanding faculty and staff who are committed to providing medical

students with an excellent educational environment. This ranking among top comprehensive medical schools also acknowledges the emphasis we place on research and clinical service."

Each year *U.S. News and World Report* surveys the top US graduate programs in 11 academic fields. Medical schools are ranked based on results of two equally weighted surveys of academic reputation, one conducted among top medical school deans and the other among intern-residency directors. There are 126 medical schools in the US.

Kentuckians at High Risk of Breast Cancer

Kentucky recently made national headlines as one of six states where women were the most likely to lose a breast to cancer.

Michael B. Flynn, MD, director of the Breast Care Center at the James Graham Brown Cancer Center, says our state's high rate of breast loss may be the environment.

"Kentucky is a largely rural area. Facilities with high-tech treatment facilities are based mainly in Louisville and Lexington," he said. "Radiation therapy, for instance, is a major time commitment — 5 to 6 weeks, 5 days a week. A patient may literally have to take up residence near a treatment area."

Dr Flynn also believes that there is a lack of health consciousness in the more rural parts of the state.

"There are many women out there who have not heard of monthly self breast examination or mammography," he said. "Many simply could not afford it if they did."

Dr Flynn stresses that early detection is the key. "A lump found through self examination shows a 50% to 60% cure rate, while an abnormality found through mammography results in a cure nearly 90% of the time."

Mobile Breast Care Unit to Serve Larger Area

U of L's Mobile Breast Care Unit has received Commission for Health Economics Control approval to expand its services throughout Kentucky.

State government now provides funds to extend screening mammography services to low-income women through county health departments. Many counties have been unable to locate a provider of this life-saving service.

The Mobile Breast Care Unit, the first in Kentucky, will provide breast education and on-site mammography to women 35 years of age and older by traveling around the state.

The unit is accredited by the American College of Radiology and is staffed by certified female technicians. Since 1990 more than 3,000 women have been screened. Most cite the convenience and low cost as the Mobile Breast Care program's most attractive features.

The recommended guidelines for screening mammography are a baseline at age 35, every one to two years from age 40-49 and annually from age 50 and older.

The exam takes 15 minutes. Results are mailed to the patient and her physician. The cost is \$50 and is payable by cash, check, Visa or MasterCard. A receipt is issued for insurance purposes.

Call 588-5264 between 8:30 am and 4:30 pm for an appointment.

UK Psychiatry Department Recognized for Partnership with State Mental Health Services

The University of Kentucky College of Medicine is one of three medical schools in the country to receive national recognition for establishing partnerships with state mental health agencies. UK's Department of Psychiatry and the Kentucky

Department for Mental Health and Retardation Services received an award from the State/University Collaboration Project of the Pew Memorial Trust.

UK was recognized for establishing a partnership with Eastern State Hospital and the Bluegrass Community Mental Health Center. All psychiatrists and most psychologists on the staff of Eastern State Hospital have faculty appointments in UK's psychiatry department. Physicians in residency training at UK receive part of their professional training in outpatient psychiatry at the Bluegrass Center. Child psychiatry fellows rotate through a separate program at outreach clinics in Harrodsburg and Danville.

Since this program began, nine graduates of UK's medical school have joined the staffs of Eastern State Hospital and the Bluegrass Center.

Dr Robert Kraus, professor of psychiatry and director of mental health research at the University's Center for Rural Health in Hazard, said the collaboration with the state greatly enhanced the university's commitment to expanding mental health services in Kentucky, particularly in rural areas.

Dr Kraus said UK is working with the Department of Mental Health to establish a statewide network to train more professionals to work in the mental health field and to make evaluation and treatment more accessible to the average Kentuckian. The Center will play a central role in mental health research and will offer programs with a rural focus, he said.

Other schools recognized for their partnerships with state mental health agencies were the University of California, Los Angeles and Pennsylvania State University.

Governor Jones Appoints Health Care Commission and Task Force

In March, Governor Brereton Jones

Journal Wins Another Award

For the second consecutive year, the *Journal of the Kentucky Medical Association* has won an Honorable Mention award in the category of state medical publications in the 17th annual medical journalism competition conducted by Sandoz Pharmaceuticals. The *Journal* was recognized for outstanding design and editorial qualities.

The Sandoz awards are highly coveted, as the competition attracts entries from all over the country and the judging is of the highest caliber.

In his critique of the *Journal*, Judge Paul Fisher, a retired journalism professor of national reputation in the publishing field, included the following comments. "In graphic achievement you rank in the top echelon . . . You have established a style that is very definitive, very effective . . . You are going in the right direction with your publication."

Sandoz Pharmaceuticals is to be congratulated for continuing this program to encourage superior medical editing and writing. The heart of their program is a series of annual teaching workshops, at which medical editors can learn from experts how to enhance both graphics and text of their publications.

Even though your *Journal* was recipient of two awards in 1991, including First Place in the American Medical Writers' Association, and now this award in 1992, Editor **A. Evan Overstreet, MD**, and his staff do not intend to remain complacent but will continue to strive to improve your publication and to vie for the prestigious first place Sandoz award. *KMA*

released the names of two groups appointed to accomplish the "goal . . . of providing quality, affordable health care to every Kentuckian."

Governor Jones said the magnitude of the challenge urged him to take a two-level approach to reform. He created a Commission on Health Care Reform by executive order, which includes representatives of executive and legislative branches. In addition, a representative from the Kentucky Health Care Access Foundation and from the University of Louisville and University of Kentucky

medical schools will serve on the Commission. The Commission's duty is to draft health care reform proposals for consideration by the General Assembly in a special session proposed for November 1992.

The second level of Governor Jones' approach consists of a Task Force on Health Care Access and Affordability. This group will hold public hearings on reform issues in area development districts around the state.

Upon completion of the statewide hearings, the Task Force

will recommend proposals to the Commission for its reform package. Human Resources Secretary Leonard Heller will chair the Commission, while House Speaker Don Blandford and Senate President Pro Tem John "Eck" rose will co-chair the Commission.

Jim Newberry, a Lexington attorney, will chair the Task Force. In addition to Newberry, 44 others will serve on the Task Force. Physicians serving on the Task Force who will represent KMA are **Russell L. Travis, MD**, Lexington; **Donald C. Barton, MD**, Corbin; **Nelson B. Rue, MD**, Bowling Green. Other physicians appointed to the Task Force are: **David T. Allen, MD**, Louisville; **Loman C. Trover, MD**, Earlington; **Peter P. Bosomworth, MD**, Lexington; **John P. Bell, MD**, Louisville; **Donald R. Kmetz, MD**, Louisville; **Beverly M. Gaines, MD**, Louisville; and **Forrest W. Calico, MD**, Lexington.

KMA will take an active role in the proceedings of both the Task Force and the Commission.

Election of HMSS Representatives Urged

The KMA Hospital Medical Staff Section (HMSS) urges each hospital medical staff to elect a representative to the Section if you have not done so. The HMSS has representatives from 77 of the 123 eligible hospital medical staffs and meets annually, usually in late summer, for a one-day business and educational meeting. The HMSS Steering Committee will soon begin planning the 1992 meeting.

In addition to educational information provided to HMSS representatives by KMA, the AMA Hospital Medical Staff Services Department is strengthening its communication to hospital medical staff representatives throughout the United States by providing the

following: *HMSS Newsletter*, mailed on a quarterly basis with *Member Matters*; an *AMA Video Journal*, which will be produced six times per year and is intended to keep physicians abreast of medicine's critical issues; hospital medical staff legal memoranda from the AMA General Counsel's office, which will provide timely legal alerts on matters affecting medical staff members; and various other AMA communications as warranted, eg, new Medicare Physician Payment System, Family Violence.

Don't miss out on receiving information that could benefit your hospital medical staff. We urge you to take advantage of these educational opportunities by encouraging your medical staff to elect a representative to be the key contact for your staff. Terms are 3 years, and more information and certification forms can be obtained by contacting the KMA Office at 502/426-6200.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

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Kenneth G. Dennison, MD — R
801 Steeplechase Rd, Glasgow 42141
1984, U of Louisville

Christian

Nancy Scott Vaught, MD — P
310 Deepwood Dr, Hopkinsville 42240
1972, Emory U

Clinton

Carol B. Peddicord, MD — IM
106 N Cross St, Albany 42602
1987, U of Kentucky

Fayette

Brian T. Nolan, MD — OPH

1401 Harrodsburg Rd B75,
Lexington 40504
1976, Columbia U

Gregory V. Osetinsky, MD — OTO
801 Rose St B363, Lexington 40536
1982, Louisiana State U

James Ritterbusch, Jr, MD — ORS
2537 Larkin Rd, Lexington 40503
1981, St. Louis U

Floyd

Juan J. Ortiz, MD — C
PO Box 1059, Prestonburg 41653
1986, Albany Medical Col

Henderson

Steven W. Kimbell, MD — P
PO Box 391, Henderson 42420
1975, U of Louisville

Jefferson

Michael G. Alt, DO — N
2525 Glenmary Ave #6, Louisville
40205
1982, Philadelphia Col of Osteopathic
Medicine

Robert A. Belza, MD — PD
4171 Westport Rd, Louisville 40207
1988, U of Kentucky

Phillip G. Fields, MD — IM
PO Box 7625, Louisville 40207
1987, Ohio State U

Michael F. Heine, MD — AN
4006 Elfin Ave, Louisville 40207
1977, U of Louisville

Steven J. Kamber, MD — PD
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1987, U of Louisville

Anthony T. Remson, MD — IM
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40241

1980, Meharry Medical Col
Leonard S. Sender, MD — PD
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1982, U of Witwaterstand

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222 Abraham Flexner #305,
Louisville 40202

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Valerie K. Waters, MD — PM
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40202

1987, State U of New York

Mark R. Wheeler, MD — IM
2510 River Oaks Dr, Louisville 40206
1987, U of Louisville
Jeffrey A. Yunkun, MD — AN
Suburban Med Plaza LLF, Louisville
40207
1987, U of Pittsburgh

Letcher

Amos Shirman, MD — FP
133 W Main St, Whitesburg 41858
1986, Ben Gurion U

McCracken

Debbie A. Dragich, MD — AN
4249 Minnich Ave, Paducah 42001
1987, Medical Col of Wisconsin

Marion

James A. Mohamed, MD — GP
One St. Mary Rd, Lebanon 40033
1961, U of Ottawa

Northern Kentucky

Michael P. Schulte, MD — FP
221 Electric Ave, Southgate 41071
1981, U of Louisville

Pike

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220 Lakeview Dr, Pikeville 41501
1987, U of Kentucky

Pulaski

Glenn M. Batiller, MD — AN
PO Box 3040, West Somerset 42564
1980, U of Philippines
Lalitkumar V. Patel, MD — AN
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1975, Vaishampayan Memorial Med
Col

Robert L. Stewart, MD — AN
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1987, U of Kentucky

Warren

Amador R. Silva, MD — OBG
PO Box 115, Bowling Green 42102
1954, Medical Col of Wisconsin

New In-Training

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Brian D. Williams, MD — OBG

Jefferson

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David E. Borden, Jr, MD — S
Susanti K. Chowdhury, MD — AN
Scott Thomas Hedges, MD — P
Norman E. Liddell, MD — C
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DEATHS

Daniel M. Munnell, MD
Richmond
1902-1992

Daniel M. Munnell, MD, a retired otolaryngologist, died February 8, 1992. A 1934 graduate of Tufts University School of Medicine, Dr Munnell was a life member of KMA.

Ballard F. Combs, MD
Lexington
1908-1992

Ballard F. Combs, MD, a retired general practitioner, died February 14, 1992. Dr Combs graduated from the University of Cincinnati College of Medicine in 1934 and was a life member of KMA.

Bernard J. Baute, MD
Lebanon
1905-1992

Bernard J. Baute, MD, a retired family physician and surgeon, died March 4,

1992. The 1992 Kentucky General Assembly, while meeting in regular session in Frankfort, approved a resolution in Dr Baute's honor. A 1929 graduate of Hahnemann Medical College, Dr Baute was a life member of KMA.

Vladimir Dvorak, MD
Frankfort
1935-1992

Vladimir Dvorak, MD, a preventive medicine specialist, died March 6, 1992. A 1960 graduate of Charles University, Czechoslovakia, Dr Dvorak was an active member of KMA.

J. Luther Fuller, MD
Louisville
1913-1992

J. Luther Fuller, MD, a retired surgeon, and former medical director for Ford Motor Company's Louisville Assembly Plant, died March 14, 1992. Dr Fuller was a private pilot and co-founded the Flying Physician's Association. A 1938 graduate of the University of Louisville School of Medicine, he was a life member of KMA.

James D. Riehm, MD
Bowling Green
1952-1992

James D. Riehm, MD, a pathologist, was killed in a helicopter crash on March 23, 1992. Dr Riehm was a 1977 graduate of the University of Louisville School of Medicine and an active member of KMA.



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‡ Verapamil should be administered cautiously to patients with impaired renal function.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully

monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecostasia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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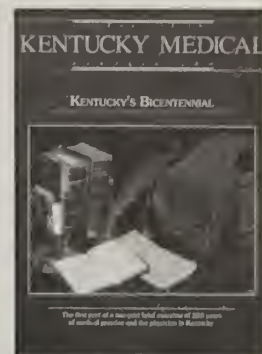


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VOLUME 90, NUMBER 6

JUNE 1992

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COVER: This typesetting represents the "office furniture" and practice needs of an 1840-50 practitioner of medicine, but the bore essentials are the saddlebags and pocket surgical kit. Books, saddlebags, stethoscope and notebak are from the museum collections of the UL Karnhauser HS Library, Louisville, Kentucky, and are used with permission. See articles beginning on page 284.

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'Now, Altogether'

Health Care Access and costs are favorite topics being discussed among many groups. Physicians, other health care providers, legislators, and the general public are working together to find solutions to these problems. If there was ever a time for physicians to work together — now is the time.

We have created part of the

"Our goal as physicians must always be to attain the best possible health care and access to medical care at an affordable cost for the citizens of the Commonwealth of Kentucky."

problem ourselves with new technology and advances in medical care, which have improved quality and allow people to live longer. Our patients are familiar with those areas of medical technology which might be applicable to their illness, and demand its use — and much of it is

costly. Elderly patients living longer require greater care in their final years of life, also fueling health care costs. Factors including advanced medical technology and elderly patients living longer are good and positive things that we would not want to alter if we could.

As you know, the Governor's Task Force has been holding forums throughout the state to discuss these problems. I hope physicians have attended and shared their thoughts on these issues in a public forum. The Task Force will report to the Governor's Commission and a plan will then be developed and presented to the Governor and considered in a special legislative session this Fall. We can expect to see major changes in the delivery of and reimbursement for health care in Kentucky.

Our goal as physicians must always be to attain the best possible health care and access to medical care at an affordable cost for the citizens of the Commonwealth of Kentucky. How do we accomplish this? We do this by supporting and promoting the eight-point program for reform advocated by KMA which sets forth reasonable proposals addressing our health care problems. We do this by working with our legislators to establish legislation dealing with these



proposals. Legislation should be directed toward tort reform, various preventive health measures, mandatory seat belt laws, drunken driving, care of the underinsured and uninsured, and other areas affecting spiraling health care costs. In addition to asking for consideration of our recommended proposals, we, as physicians, must ask ourselves — What can we do personally to do our part in alleviating this crisis?

KMA has more members now than at any time in its history. This reflects the fact that Kentucky physicians now recognize that only by working together through organized medicine can we achieve the goals we have set. It reminds me of the caption on that famous picture of a group of Marines raising the flag on Iwo Jima — "Now — Altogether." Let's Do It — *All Together*.

S. Randolph Scheen, MD
President



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Defending Defensible Doctors

Unilateral Diaphragmatic Paralysis: A Matter for Concern

Karen R. Habenstein, MD; David S. Overstreet, MD;
Van Q. Nguyen, MD; Ryland P. Byrd, Jr., MD

A dilemma often faces the clinician who is asked to evaluate unilateral elevation of a hemidiaphragm that is identified on routine chest roentgenogram. The possibilities include neoplasm, infection, neuromuscular disease, trauma, or benign etiologies. We present an asymptomatic patient with this finding to provide some guidelines for the nature and extent of further investigation of unilateral diaphragmatic paralysis.

Introduction

The causes of diaphragmatic paralysis are multiple and diverse. Unilateral disease occurs most commonly. The problem facing the clinician is that unilateral diaphragmatic paralysis may be entirely benign or may be a herald sign of a life-threatening disease. In many instances the etiology is not obvious and may never be determined.¹ Since recovery of diaphragmatic function often cannot be expected, the practitioner should benefit from guidelines that suggest when the workup of unilateral diaphragmatic elevation can be reasonably terminated.

Case Report

The patient, a 56-year-old female, was found to have an elevated right hemidiaphragm on a PA chest radiograph that was obtained as part of a pre-employment physical. At the time of the radiographic examination, she was asymptomatic and gave an unremarkable account of her past medical history. She specifically denied chest pain, trauma, fever, chills, weight loss, cough, hemoptysis, or exposure to infectious disease. She admitted only to a mild increase in dyspnea on exertion that was not severe enough to limit her activities.

Dullness to percussion and absent tactile fremitus was detected in the right posterior base. Diaphragmatic excursion, as measured by reso-



Fig 1 — PA chest radiograph obtained in asymptomatic patient reveals an elevated right hemidiaphragm and the suggestion of a right hilar mass.

nance to percussion, was 2.5 cm on the left and absent on the right. Auscultation of the right chest revealed inspiratory crackles in the mid lung field and absence of breath sounds in the area that would mirror the left posterior base. Her abdominal examination was remarkable for paradoxical inward motion at the right anterior costal margin on deep inspiration.

The chest radiograph (Fig 1) was interpreted

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Unilateral Diaphragmatic Paralysis

as free of active disease. Attention was drawn to the presence of an elevated right hemidiaphragm and a questionable right hilar mass. Fluoroscopic evaluation of the excursion of each diaphragm confirmed that the right hemidiaphragm failed to move significantly with the "sniff test." Furthermore, it would move only slightly, in a disorganized fashion, when the patient performed deep breathing maneuvers while in a position greater than 45 degrees to the horizontal plane. The right hilar mass failed to change diameter with deep respiratory movements and was determined not to be of vascular origin.

Flexible fiberoptic bronchoscopy was performed. No endobronchial lesions were visible. An endoscopic guided needle aspiration biopsy was obtained with a Wang needle from the right hilar area. This tissue demonstrated primary bronchogenic neoplasm of the small cell histology.

Discussion

Unilateral diaphragmatic paralysis rarely causes severe respiratory compromise and its presence is often initially suggested only by the patient's chest radiograph. The sparsity of respiratory symptoms is due to successful recruitment of intercostal and abdominal muscles.² Reduced exercise tolerance with dyspnea is found in about 24% of subjects with unilateral diaphragmatic paralysis.³ Mild orthopnea is a frequent complaint, but is less severe than in patients with bilateral paralysis. Tachypnea is occasionally reported.⁴

Physical signs are usually nonspecific. Paradoxical motion of the paralyzed diaphragm may be suggested by percussion of the thorax. Asymmetric motion of the abdominal wall in the supine position is often observed. There may be an associated reduction in breath sounds at the lung base on the affected side.³

Once diaphragmatic paralysis is suggested by the finding of an elevated hemidiaphragm on radiographic or physical examination, the cause can usually be determined in 40% of patients at the initial diagnostic evaluation using the patient's history, ancillary physical findings, and additional clues from the plain chest roentgenogram. These investigations usually reveal the cause to be infectious, neuromuscular, traumatic, iatrogenic, or neoplastic.

The most common cause of unilateral diaphragmatic paralysis is malignancy due to bronchial carcinoma, as occurred in our patient.³ This was the diagnosis in one third of 105 patients

with an identifiable cause of unilateral paralysis. Another one third had a history of thoracic or neck operations resulting in intentional or accidental phrenic nerve injury. The remaining one third of patients had paralysis related to trauma, infection, or neurological disease.¹ These other causes of unilateral diaphragmatic paralysis include pneumonia, subclavian vein cannulation, and herpes zoster affecting the cervical nerve roots, spinal cord injury, cervical spondylosis, poliomyelitis, late onset muscular dystrophy, measles, typhoid, diphtheria, mediastinitis, aortic aneurysms, B-thalassemia major, and carbon monoxide poisoning.^{3,5}

As alluded to above, often the etiology will remain unexplained. In a study looking at 142 patients referred to the Mayo Clinic for unexplained diaphragmatic paralysis, intrathoracic malignant lesions with phrenic nerve involvement was identified in only 3.5% of patients and progressive neurogenic atrophy in one patient (0.7%). Only 12 persons demonstrated resolution of normal diaphragmatic position (9.2%). This study is reassuring to the primary care provider, suggesting that, after a proper assessment, the majority of patients with unexplained diaphragmatic paralysis are unlikely to have an occult malignancy or neurological process. Unfortunately they are also unlikely to show recovery of diaphragmatic function.¹

Increasingly, unilateral diaphragmatic paralysis has been associated with cardioplegia from isolated hypothermia, and this represents an important etiology that needs to be recognized by the primary care physician in light of the increasing numbers of cardiac bypass surgeries performed as the general population ages.⁶ The true incidence of phrenic nerve injury with resultant diaphragmatic dysfunction after cardiac surgery ranges from 0.2% to 10%,⁴ but is thought to be underreported depending on the methods used to evaluate the phrenic nerves. Unilateral left diaphragmatic paralysis is the more common complication, but bilateral and right-sided paralysis have also been reported.^{4,7,8}

Because of their close proximity to the heart, the phrenic nerves can be easily injured during coronary artery bypass surgery.⁸ Inadvertent sectioning is rare, but physical injury due to stretching or compression is common during exposure of the heart or with dissection of the internal mammary artery used for the graft.^{4,8}

Phrenic nerve injury has also been reported to occur primarily as the result of hypothermic

injury related to the use of topical cold cardioplegia during coronary artery bypass surgery.^{4,8} The phrenic nerves lie within the fibrous pericardium, having been invested within the pleuropericardial membranes during descent from the phrenic nerve nuclei. Experimentally, damage to large myelinated fibers has been shown to occur with 8°C exposure for as little as 30 minutes.

No known intervention will hasten recovery from hypothermia. Radiographic recovery of the diaphragm to normal position occurs in 20% of patients at 1 month, 50% at 1 year, and 97% at 2 years.⁷

Traditionally percussion of the chest wall has been used to determine the position and range of movement of the diaphragm. The dome of the diaphragm ranges from 10 to 15 cm from the chest wall and moves more than the periphery of the diaphragm. Clinical interest is in regard to movement of the dome of the diaphragm, making measurement of peripheral diaphragmatic excursion an imprecise estimate of actual diaphragmatic function. In fact, clinical measurements of diaphragmatic movement show limited value in determining the diagnosis of physiologic impairment.⁹

Although the chest roentgenograms showing a unilateral elevated hemidiaphragm and reduced lung volume with or without basilar atelectasis is often the first clue to diaphragmatic paralysis, one retrospective study suggests that it is neither sensitive nor specific for determining diaphragmatic dysfunction.⁴ Other indicators of diaphragmatic dysfunction should be employed.

Pulmonary function tests in diaphragmatic paralysis are consistent with a restrictive defect with reduced lung volumes, normal flow rates, and a relative increase in residual volume. Unlike patients with global respiratory muscle weakness, the expiratory reserve volume is relatively preserved in diaphragmatic paralysis.³ The simplest test in screening for diaphragmatic impairment is to measure the erect and supine vital capacity.² In the erect position, vital capacity is well preserved because gravitational force improves the mechanical advantage of the accessory muscles of respiration. In the supine position, the abdominal contents encroach into the thorax resulting in reduced vital capacity with subsequent increased work of breathing.² Normal subjects show a reduction of as much as 20% of vital capacity in the supine position.³ Unilateral diaphragmatic paralysis results in a decline in VC which is greater than expected.³ With unilateral diaphragmatic paraly-

sis, the VC of seated patients is reduced to approximately 75% of predicted, and an additional decline of 10% to 20% occurs when the patient lies flat.¹⁰

Fluoroscopy is the best established method of assessing diaphragmatic function. It is more sensitive in the diagnosis of unilateral diaphragmatic paralysis where paradoxical motion of one complete hemidiaphragm is seen during the "sniff test." Fluoroscopy may reveal impaired descent on the affected side during inspiration, and typically an upward shift of that diaphragm during a sniff. Paradoxical motion should be at least 2 cm for a confident diagnosis of paralysis.³ However, observations may be inconclusive or misleading if the patient breathes with a pattern of active expiration followed by passive inspiration in the upright position, which may falsely lower the dome of the diaphragm from negative intra-abdominal pressure.¹¹

Maximal inspiratory and expiratory pressure measurements can be used as indicators of global inspiratory and expiratory muscle strength.² These indices are easily measured at the mouth or endotracheal tube using a closed-end, large-bore tube with a pressure gauge.⁴ P_{lmax} (maximal static inspiratory pressure) is the maximum pressure achieved from residual volume, and P_E_{max} (maximal static expiratory pressure) is the maximum pressure generated from total lung capacity. Diaphragmatic dysfunction results in low maximal inspiratory pressures (P_{lmax}) to 43% of predicted.⁴ P_E_{max} is generally not affected by diaphragmatic dysfunction and has been reported normal in all patients in one study.⁸

A transdiaphragmatic pressure measurement could provide a quantitative index of diaphragmatic contractility,² but the tension developed by the diaphragm cannot be measured directly. Instead, the measurement of transdiaphragmatic pressure is determined as the difference between intragastric pressure and esophageal pressure (pleural pressure) using balloon manometers. Diaphragmatic contraction during quiet breathing is usually associated with an increase in positive gastric pressure and a decrease in pleural pressure. With diaphragmatic paralysis, changes in gastric pressure show a reduced amplitude and sometimes become more negative during inspiration resulting in little or no change in the transdiaphragmatic pressure during the inspiratory maneuver.^{2,3} This type of testing is cumbersome and uncomfortable.

Phrenic nerve stimulation with diaphrag-

Unilateral Diaphragmatic Paralysis

matic EMG and phrenic nerve conduction times may be useful adjuvants in locating the site and nature of the lesion contributing to dysfunction.³ These more sophisticated studies are sometimes used to assess neuropathic or myopathic conditions of the diaphragm or defects in phrenic nerve conduction.² Electromyelographic activity in the diaphragm can be recorded with either esophageal or surface electrodes. The surface electrodes are more commonly used and recordings are made during spontaneous breathing or during electrical stimulation of the phrenic nerve in the neck.³ Normal phrenic nerve conduction time in adults is approximately 9.5 milliseconds. Normal diaphragmatic excursion after phrenic nerve stimulation is 6 cm or more. Less than 6 cm excursion represents mild impairment and less than 2 cm excursion represents severe impairment of diaphragmatic contraction.⁴

Investigation of diaphragmatic function in cases of suspected paralysis is usually restricted to measurements of lung volumes and to the visualization of diaphragmatic movement by fluoroscopy. Methods for measuring phrenic nerve conduction based on recording the diaphragmatic muscle action potential either with esophageal electrodes or surface electrodes over the lateral chest wall have not found general application. Thus in clinical practice, the diagnosis of diaphragm paralysis in the majority of cases rests principally on fluoroscopic evidence combined with clinical examination, positional changes in Vital Capacity (VC) and a measurable decrease in Plmax.

Only limited options exist for treatment of unilateral diaphragmatic paralysis. Although most patients with unilateral diaphragmatic dysfunction have minimal to no symptoms, some patients report persistent dyspnea on exertion and orthopnea with impairment of pulmonary function. Diaphragmatic plication has been reported to produce symptomatic improvement along with significant improvement in FEV1, FVC, lung volumes, and a reduction in positional changes of Vital Capacity.¹² The procedure is performed through a thoracotomy incision and the diaphragm is plicated in successive layers until it is drawn taut. Shortening and stiffening of the diaphragm restores a more normal position which reduces paradoxical motion. Both oxygen-

ation and ventilation are improved. Diaphragmatic plication is reported to be durable, safe and effective.¹³

We hope that this review will provide a suitable template for approaching the asymptomatic patient who is discovered to have an elevation of a hemidiaphragm on chest radiograph. When this finding attracts the attention of a physician competent in the art of history taking and physical examination, a malignant etiology is almost always immediately identifiable. Likewise, an unexplained elevated hemidiaphragm in an asymptomatic patient evaluated by an adept physician is likely due to a benign etiology and only assurance is necessary.

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‡ In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.

ACCUPRIL is available in 10, 20, and 40 mg tablets. Usual initial starting dosage is 10 mg once daily.

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Please see brief summary of prescribing information on following page.



Accupril® (Quinapril Hydrochloride Tablets)

USE IN PREGNANCY

When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, ACCUPRIL should be discontinued as soon as possible. See WARNINGS, Fetal/Neonatal Morbidity and Mortality.

Before prescribing, please see full prescribing information. A brief summary follows.

INDICATIONS AND USAGE

ACCUPRIL is indicated for the treatment of hypertension. It may be used alone or in combination with thiazide diuretics.

In using ACCUPRIL, consideration should be given to the fact that another angiotensin-converting enzyme (ACE) inhibitor, captopril, has caused agranulocytosis, particularly in patients with renal impairment or collagen vascular disease. Available data are insufficient to show that ACCUPRIL does not have a similar risk (see WARNINGS).

CONTRAINDICATIONS

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

WARNINGS

Angioedema: Angioedema of the face, extremities, lips, tongue, glottis, and larynx has been reported in patients treated with ACE inhibitors and has been seen in 0.1% of patients receiving ACCUPRIL. Angioedema associated with laryngeal edema can be fatal. If laryngeal stridor or angioedema of the face, tongue, or glottis occurs, treatment with ACCUPRIL should be discontinued immediately, the patient treated in accordance with accepted medical care, and carefully observed until the swelling disappears. In instances where swelling is confined to the face and lips, the condition generally resolves without treatment; antihistamines may be useful in relieving symptoms. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, emergency therapy including, but not limited to, subcutaneous epinephrine solution 1:1000 (0.3 to 0.5 mL) should be promptly administered (see ADVERSE REACTIONS).**

Hypotension: Symptomatic hypotension was rarely seen in uncomplicated hypertensive patients treated with ACCUPRIL, but, as with other ACE inhibitors, it is a possible consequence of therapy in salt/volume depleted patients, such as those previously treated with diuretics or dietary salt restriction or who are on dialysis (see PRECAUTIONS, DRUG INTERACTIONS, AND ADVERSE REACTIONS). In controlled studies, syncope was observed in 0.4% of patients (N = 3203); this incidence was similar to that observed for captopril (1%) and enalapril (0.8%).

In patients with concomitant congestive heart failure, with or without associated renal insufficiency, ACE inhibitor therapy may cause excessive hypotension, which may be associated with oliguria or azotemia and, rarely, with acute renal failure and death. In such patients, ACCUPRIL therapy should be started at the recommended dose under close medical supervision. These patients should be followed closely for the first 2 weeks of treatment and whenever the dosage of antihypertensive medication is increased (see DOSAGE AND ADMINISTRATION).

If symptomatic hypotension occurs, the patient should be placed in the supine position and, if necessary, normal saline may be administered intravenously. A transient hypotensive response is not a contraindication to further doses; however, lower doses of ACCUPRIL or reduced concomitant diuretic therapy should be considered.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression rarely in patients with uncomplicated hypertension, but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease such as systemic lupus erythematosus or scleroderma. Agranulocytosis did occur during ACCUPRIL treatment in one patient with a history of neutropenia during previous captopril therapy. Available data from clinical trials of ACCUPRIL are insufficient to show that, in patients without prior reactions to other ACE inhibitors, ACCUPRIL does not cause agranulocytosis at similar rates. As with other ACE inhibitors, periodic monitoring of white blood cell counts in patients with collagen vascular disease and/or renal disease should be considered.

Fetal/Neonatal Morbidity and Mortality: ACE inhibitors can cause fetal and neonatal morbidity and death when administered to pregnant women. Several dozen cases have been reported in the world literature. When pregnancy is detected, ACE inhibitors should be discontinued as soon as possible.

The use of ACE inhibitors during the second and third trimesters of pregnancy has been associated with fetal and neonatal injury, including hypotension, neonatal skull hypoplasia, anuria, reversible or irreversible renal failure, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios in this setting has been associated with fetal limb contractures, craniofacial deformation, and hypoplastic lung development. Prematurity, intrauterine growth retardation, and patent ductus arteriosus have also been reported, although it is not clear whether these occurrences were due to the ACE inhibitor exposure.

These adverse effects do not appear to have resulted from intrauterine ACE inhibitor exposure that has been limited to the first trimester. Mothers whose embryos and fetuses are exposed to ACE inhibitors only during the first trimester should be so informed. Nonetheless, when patients become pregnant, physicians should make every effort to discontinue the use of ACCUPRIL as soon as possible.

Rarely (probably less often than once in every thousand pregnancies), no alternative to ACE inhibitors will be found. In these rare cases, the mothers should be apprised of the potential hazards to their fetuses, and serial ultrasound examinations should be performed to assess the intraamniotic environment.

If oligohydramnios is observed, ACCUPRIL should be discontinued unless it is considered life-saving for the mother. Contraction stress testing (CST), a non-stress test (NST), or biophysical profiling (BPP) may be appropriate, depending upon the week of pregnancy. Patients and physicians should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible injury.

Infants with histories of *in utero* exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as a means of reversing hypotension and/or substituting for disordered renal function.

Removal of ACCUPRIL, which crosses the placenta, from the neonatal circulation is not significantly accelerated by these means. No teratogenic effects of ACCUPRIL were seen in studies of pregnant rats and rabbits. On a mg/kg basis, the doses used were up to 180 times (in rats) and one time (in rabbits) the maximum recommended human dose.

PRECAUTIONS

General

Impaired renal function: As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including ACCUPRIL, may be associated with oliguria and/or progressive azotemia and rarely acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine have been observed in some patients following ACE inhibitor therapy. These increases were almost always reversible upon discontinuation of the ACE inhibitor and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some hypertensive patients with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when ACCUPRIL has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of any diuretic and/or ACCUPRIL may be required.

Evaluation of hypertensive patients should always include assessment of renal function (see DOSAGE AND ADMINISTRATION).

Hyperkalemia and potassium-sparing diuretics: In clinical trials, hyperkalemia (serum potassium ≥ 5.8 mmol/L) occurred in approximately 2% of patients receiving ACCUPRIL. In most cases, elevated serum potassium levels were isolated values which resolved despite continued therapy. Less than 0.1% of patients discontinued therapy due to hyperkalemia. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with ACCUPRIL (see PRECAUTIONS, Drug Interactions).

Cough: Cough has been reported with the use of ACE inhibitors. Characteristically, the cough is nonproductive, persistent, and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

Surgery/anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, ACCUPRIL will block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients

Pregnancy: Female patients of childbearing age should be told about the consequences of second- and third-trimester exposure to ACE inhibitors, and they should also be told that these consequences do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. These patients should be asked to report pregnancies to their physicians as soon as possible.

Angioedema: Angioedema, including laryngeal edema, can occur with treatment with ACE inhibitors, especially following the first dose. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to stop taking the drug until they have consulted with their physician (see WARNINGS).

Symptomatic hypotension: Patients should be cautioned that lightheadedness can occur, especially during the first few days of ACCUPRIL therapy, and that it should be reported to a physician. If actual syncope occurs, patients should be told to not take the drug until they have consulted with their physician (see WARNINGS).

All patients should be cautioned that inadequate fluid intake or excessive perspiration, diarrhea, or vomiting can lead to an

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excessive fall in blood pressure because of reduction in fluid volume, with the same consequences of lightheadedness and possible syncope.

Patients planning to undergo any surgery and/or anesthesia should be told to inform their physician that they are taking an ACE inhibitor.

Hyperkalemia: Patients should be told not to use potassium supplements or salt substitutes containing potassium without consulting their physician (see PRECAUTIONS).

Neutropenia: Patients should be told to report promptly any indication of infection (eg, sore throat, fever) which could be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with ACCUPRIL is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions

Concomitant diuretic therapy: As with other ACE inhibitors, patients on diuretics, especially those on recently instituted diuretic therapy, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with ACCUPRIL. The possibility of hypotensive effects with ACCUPRIL may be minimized by either discontinuing the diuretic or cautiously increasing salt intake prior to initiation of treatment with ACCUPRIL. If it is not possible to discontinue the diuretic, the starting dose of quinapril should be reduced (see DOSAGE AND ADMINISTRATION).

Agents increasing serum potassium: Quinapril can attenuate potassium loss caused by thiazide diuretics and increase serum potassium when used alone. If concomitant therapy of ACCUPRIL with potassium-sparing diuretics (eg, spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes is indicated, they should be used with caution along with appropriate monitoring of serum potassium (see PRECAUTIONS).

Tetracycline and other drugs that interact with magnesium: Simultaneous administration of tetracycline with ACCUPRIL reduced the absorption of tetracycline by approximately 28% to 37%, possibly due to the high magnesium content in ACCUPRIL tablets. This interaction should be considered if coprescribing ACCUPRIL and tetracycline or other drugs that interact with magnesium.

Lithium: Increased serum lithium levels and symptoms of lithium toxicity have been reported in patients receiving concomitant lithium and ACE inhibitor therapy. These drugs should be co-administered with caution, and frequent monitoring of serum lithium levels is recommended. If a diuretic is also used, it may increase the risk of lithium toxicity.

Other agents: Drug interaction studies of ACCUPRIL with other agents showed:

- Multiple dose therapy with propranolol or cimetidine has no effect on the pharmacokinetics of single doses of ACCUPRIL.
- The anticoagulant effect of a single dose of warfarin (measured by prothrombin time) was not significantly changed by quinapril coadministration twice-daily.
- ACCUPRIL treatment did not affect the pharmacokinetics of dioxin.
- No pharmacokinetic interaction was observed when single doses of ACCUPRIL and hydrochlorothiazide were administered concomitantly.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Quinapril hydrochloride was not carcinogenic in mice or rats when given in doses up to 75 or 100 mg/kg/day (50 to 60 times the maximum human daily dose, respectively, on a mg/kg basis and 3.8 to 10 times the maximum human daily dose when based on a mg/m² basis) for 104 weeks. Female rats given the highest dose level had an increased incidence of mesenteric lymph node hemangiomas and skin/subcutaneous lipomas. Neither quinapril nor quinaprilate were mutagenic in the Ames bacterial assay with or without metabolic activation. Quinapril was also negative in the following genetic toxicology studies: *in vitro* mammalian cell point mutation, sister chromatid exchange in cultured mammalian cells, micronucleus test with mice, *in vitro* chromosome aberration with V79 cultured lung cells, and in an *in vivo* cytogenetic study with rat bone marrow. There were no adverse effects on fertility or reproduction in rats at doses up to 100 mg/kg/day (60 and 10 times the maximum daily human dose when based on mg/kg and mg/m², respectively).

Pregnancy

Pregnancy Categories C (first trimester) and D (second and third trimesters): See WARNINGS, Fetal/Neonatal Morbidity and Mortality.

Nursing Mothers

It is not known if quinapril or its metabolites are secreted in human milk. Quinapril is secreted to a limited extent, however, in milk of lactating rats (5% or less of the plasma drug concentration was found in rat milk). Because many drugs are secreted in human milk, caution should be exercised when ACCUPRIL is given to a nursing mother.

Geriatric Use

Elderly patients exhibited increased area under the plasma concentration time curve (AUC) and peak levels for quinapril compared to values observed in younger patients; this appeared to relate to decreased renal function rather than to age itself. In controlled and uncontrolled studies of ACCUPRIL, where 918 (21%) patients were 65 years and older, no overall differences in effectiveness or safety were observed between older and younger patients. However, greater sensitivity of some older individual patients cannot be ruled out.

Pediatric Use

The safety and effectiveness of ACCUPRIL in children have not been established.

ADVERSE REACTIONS

ACCUPRIL has been evaluated for safety in 4960 subjects and patients. Of these, 3203 patients, including 655 elderly patients, participated in controlled clinical trials. ACCUPRIL has been evaluated for long-term safety in over 1400 patients treated for 1 year or more.

Adverse experiences were usually mild and transient.

Discontinuation of therapy because of adverse events was required in 4.7% of patients treated with ACCUPRIL in placebo-controlled hypertension trials.

Adverse experiences probably or possibly related to therapy or of unknown relationship to therapy occurring in 1% or more of the 1563 patients in placebo-controlled hypertension trials who were treated with ACCUPRIL are shown below.

Adverse Events in Placebo-Controlled Trials

	ACCUPRIL (N = 1563) Incidence (Discontinuation)	Placebo (N = 579) Incidence (Discontinuation)
Headache	5.6 (0.7)	10.9 (0.7)
Dizziness	3.9 (0.8)	2.6 (0.2)
Fatigue	2.6 (0.3)	1.0
Coughing	2.0 (0.5)	0.0
Nausea/Vomiting	1.4 (0.3)	1.9 (0.2)
Abdominal Pain	1.0 (0.2)	0.7

See PRECAUTIONS, Cough.

Clinical adverse experiences probably or possibly related, or of uncertain relationship to therapy, occurring in 0.5% to 1.0% (except as noted) of the patients treated with ACCUPRIL (with or without concomitant diuretic) in controlled or uncontrolled trials (N = 4397) and less frequent, clinically significant events seen in clinical trials or post-marketing experience (the rarer events are in italics) include (listed by body system):

General: back pain, malaise

Cardiovascular: palpitation, vasodilation, tachycardia, heart failure, hyperkalemia, myocardial infarction, cerebrovascular accident, hypertensive crisis, angina pectoris, orthostatic hypotension, cardiac rhythm disturbances

Gastrointestinal: dry mouth or throat, constipation, gastrointestinal hemorrhage, pancreatitis, abnormal liver function tests

Nervous/Psychiatric: somnolence, vertigo, syncope, nervousness, depression

Integumentary: increased sweating, pruritus, exfoliative dermatitis, photosensitivity reaction

Urogenital: acute renal failure

Other: amblyopia, pharyngitis, sinusitis, bronchitis, agranulocytosis, thrombocytopenia

Fetal/Neonatal Morbidity and Mortality

See WARNINGS, Fetal/Neonatal Morbidity and Mortality.

Angioedema: angioedema has been reported in patients receiving ACCUPRIL (0.1%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with ACCUPRIL should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Clinical Laboratory Test Findings

Hematology: (See WARNINGS)

Hyperkalemia: (See PRECAUTIONS)

Creatinine and blood urea nitrogen: Increases (71.25 times the upper limit of normal) in serum creatinine and blood urea nitrogen were observed in 2% and 2%, respectively, of patients treated with ACCUPRIL alone. Increases are more likely to occur in patients receiving concomitant diuretic therapy than in those on ACCUPRIL alone. These increases often remit on continued therapy.

*In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.

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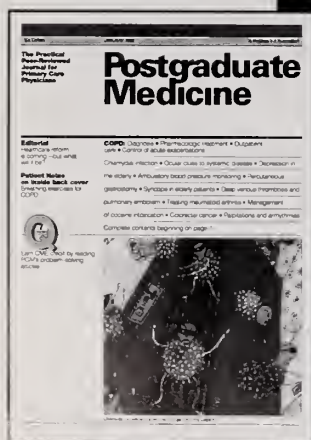
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Kentucky's Bicentennial and a Brief Overview of 200 Years of Medical Practice and the Physician

Eugene H. Conner, MD

The first part of a two-part section



My colleagues on the Editorial Board have invited me, as your KMA Historian, to prepare a few pages in observance of the Bicentennial of Kentucky. We will have the first part of a two-part section in the June issue to coincide with our becoming the 15th state on the second of June 1792.

There is much that could be said about the two centuries of history in our state and the contributions by the medical profession to the health and welfare of our fellow citizens, but I have, by necessity, shortened my account. Despite the brevity, I have attempted to touch the "high spots" in the labors of individual physicians and our state society as a functional entity reflecting the desires and foresight of our many members.

—EUGENE H. CONNER, MD
KMA HISTORIAN

On the first day of June 1792, a momentous change took place in Kentucky's judicial, representative, and civil government as our ancestors assumed a new identity. The US Congress, under provisions of the US Constitution (Article IV, Sect 3, par 1) declared this westernmost county of Virginia the 15th state — the second state to be added to the original 13.

This occurrence was the culmination of events spanning more than a decade beginning with largely unheeded requests to authorities in the East for assistance in defending this land against the British and the Indian nations. The first halting steps toward statehood took place in March 1783, when the four counties (Fayette, Lincoln, Jefferson, founded in 1780, and Nelson, founded in 1781), into which the former Kentucky county had been divided, were formed into one District so that a District Court could be established.

Following a series of five conventions, the Commonwealth of Virginia and the delegation from Kentucky finally accepted terms for separation of all that had once been Kentucky County from Virginia's jurisdiction. By May 1792, the first Constitution of the State of Kentucky had been written, submitted to the vote of delegates, and ratified by the Kentucky Constitutional Convention, held in Danville.¹

It has been rewritten several times (1799, 1847, 1891) and amended on numerous occasions over these intervening two centuries.

Medical men have always been present in the growing numbers of people who are called Kentuckians, be they native-born or immigrant. First into the wilderness were men and women with pioneering instincts seeking a better life in a new land. These people were independent, self-sustaining individuals who gave freely of their talents, labor, and supplies to their fellow immigrants and neighbors.

Income from the practice of medicine in the late 18th century — except in the larger cities on the east coast — was not sufficient to sustain a physician, who, therefore, had to find other means to supply his table. Many men trained in medicine were also farmers, shopkeepers, or traders. This alternate means of support was necessary for several reasons:

First, population was quite sparsely settled on the frontier and except in small villages or near stations (fortified or more readily defendable dwellings), there were often great distances between neighbors.

Second, people of the 18th and 19th centuries relied upon their own knowledge and experience for the "common-sense" management of ague, flux and pleurisy — at that time, categories by which the most common disorders were identified. These folks, when ill, did not send for the nearest physician; they treated themselves and neighbors as best they knew how. They bled, purged, "puked," or sweat the patients; sometimes all four of these actions were deemed essential treatment.

Third, the citizens knew from observation that the physician was perhaps not as well acquainted with what to prescribe or advise, as their own experience would suggest. Occasionally, in obscure illnesses or during frightful epidemics (e.g., smallpox and later, cholera) families might rely upon the advice of a trusted slave or friendly Indian for medical advice and treatment with local plants whose medicinal properties were thought to be of use in a variety of complex disorders.

Home medical guides and home medicine chests, which had been important sources of guidance and therapy for seafarers and immigrants to the frontiers of the new worlds of the 18th and 19th centuries, were available and, by the appearance of surviving examples, were ex-

Brief Overview of 200 Years of Medical Practice: Part I

tensively used. As the frontier in the New West was pushed farther west, physicians in the newer settlements provided their fellow citizens with domestic medical guides, e.g., T. W. Rubel, Richmond, Kentucky, 1810; James Ewell, Savannah, Georgia, 1817; John Gunn of Tennessee and Kentucky, 1830. Even medical guides for mothers began to appear (J. W. Bright, Louisville, 1844).

The practice of medicine during the conquest of the frontier and the period of rising nationalism, was relatively simple; the physician had access to no precision equipment except a pocketwatch by which to count the pulse, and his diagnosis was based upon history and what his five senses could tell him. (The stethoscope was not in common use until about 1850, and clinical thermometers — for axillary temperature measurement only — did not find application until the 1860s.) He carried his store of drugs and small case of surgical instruments in his pockets or his saddlebags.

There were physicians among the early settlers and even among the first explorers. Dr Thomas Walker, who first crossed the Cumberland into Kentucky in 1750, was a physician as well as an explorer and surveyor. Dr William Fleming, better known as Colonel William Fleming, Land Commissioner, was surveying at the Falls of the Ohio in 1779.^{2a} He had been a practicing physician in Staunton, Augusta County, Virginia (on the eastern portion of the Wilderness Road), but he, too, is better known as an explorer and surveyor in Kentucky. These two gentlemen preceded the first wave of immigrants among whom were several physicians. George Hart came to Fort Harrod in 1775, then to Jefferson County in 1779. The busiest medical practitioner at Fort Harrod was Jane Coomes who, as a school teacher, came west with Dr Hart and her husband William. She was the first female to practice medicine in Kentucky although we do not know from whom she acquired her skills.^{2b} Among the early practitioners³ in Louisville were Alexander Skinner (1784), Absalom Bainbridge (1790), James O'Fallon (1791), Benjamin Johnson (1791), William Craig Galt (1802), and Richard Ferguson (1803). There were three physicians practicing in Bardstown, Nelson County, before 1806 — Walter Brashier, Burr Harrison, and John Goodtell. One of the earliest physicians practicing in Washington, Mason County, was John Johnston in 1785, who was soon joined by William Goforth in 1788. The first practicing physician in Jessamine County was

Peter Trislet in 1791, a native of Germany who had first practiced in Maryland.

Physicians became immigrants themselves for reasons similar to those that motivated most other settlers to come west of the Allegheny Mountains. They came to purchase good, inexpensive land or simply to try their fortune in a new place. As populations grew — mostly with newcomers — the density of citizens became sufficient in larger towns to support a physician. From an examination of the advertisements in Kentucky newspapers printed before 1820, one can readily determine that some physicians settled in a community and stayed, while others remained but a short period and then moved farther west.⁴ At least one, it turns out, was a fugitive from justice in Philadelphia.⁵

By the end of the 18th century, the number of physicians had grown in Kentucky's largest town (Lexington), and their presence attracted young apprentices to the study of medicine. Not long after Kentucky achieved statehood, the General Assembly settled an ugly and prolonged struggle concerning the "seminary of learning" provided for by the Virginia legislature in 1780. The Kentucky lawmakers, in 1798, declared Lexington the location of this "seminary" and renamed it Transylvania University.⁶ This, in effect, was the beginning of higher education in Kentucky — just 6 years after statehood had been achieved.

The next fundamental step towards the advancement of medicine concerns the appointments, in 1799, of two physicians as professors in the Medical Department of Transylvania University. Frederick Ridgely, MD (1757-1824),⁷ a native of Maryland and a veteran surgeon of the Revolutionary War, had received his medical instruction in Philadelphia from the faculty of the University of Pennsylvania from which he took no medical degree. He had come to Lexington in 1790, and was soon practicing with Basil Duke, MD. Ridgely's appointment at Transylvania was as Professor of *Materia Medica*, Midwifery and the Practice of Physic. Samuel Brown, MD (1769-1830),⁸ of Lexington (MD, Aberdeen, Scotland, 1795), was appointed Professor of Chemistry, Anatomy, and Surgery. These two professors, although they had no school edifice, delivered lectures to a small class of medical students in Lexington, perhaps in a vacant warehouse or their own offices, during the winter of 1799-1800. Most likely receiving no pay from the Transylvania Trustees, they probably

collected fees from the students in attendance.

The medical faculty was not effectively organized as The Medical Department of Transylvania University until 1817, and regular lectures by a complete medical faculty did not resume on an annual basis until 1823; however, medical lectures had been started in 1799⁹ and assisted immeasurably in securing the second step toward a medical profession in Kentucky, nurtured and guided by an institutionalized faculty and system of teaching.

By the beginning of the 19th century, the presence of a medical community in Kentucky had been manifested not only by the care provided by the relatively few practitioners, but by their efforts throughout the state to teach the "science and mysteries" of medicine to apprentices and students. It is likely that all medical students in Lexington, even those receiving instruction from preceptors other than Transylvania faculty appointees, attended meetings at Transylvania University.¹⁰

The first student-faculty medical society,¹¹ The Lexington Medical Society, began to publish meeting notices in the *Kentucky Gazette* in the fall of 1803, but had been organized the preceding year.¹² A lottery had been authorized by the General Assembly in 1803, for benefit of the Lexington Medical Society.¹³

Student-faculty medical societies had been an integral part of medical students' activities during the 18th and 19th centuries, whether in Leyden, Holland; Edinburgh, Scotland; or the first medical college in the United States — the Medical Department of the College of Philadelphia (Univ PA). These societies provided an opportunity to meet the faculty on a less formal basis than the lecture room. The importance of unstructured conversation as a method of teaching and learning medicine was perhaps here inculcated in some students who later would organize and support local, regional, and state medical societies when they began practice, in order to be assured of continuing medical education.

The influence of "faculty" members at medical lectures, whether there was a fully functional medical institution in the town or not, was extremely important, for it was by these men that concepts of disease and its medical treatment were carried from Europe, the British Isles, and the Eastern coastal cities of the US to the transmontane West. Later, during this first century of our statehood, additional practitioners came with

new ideas. Men like Charles Caldwell, MD (UPA, 1796), Benjamin Winslow Dudley, MD (UPA, 1806), Charles Wilkins Short, MD (UPA, 1815), Daniel Drake, MD (UPA, 1816), Henry Miller, MD (Transy, 1822), Lunceford P. Yandell, MD (UMD, 1825), Joshua Barker Flint, MD (Harvard, 1825) and numerous others leavened the art and science of medicine in Kentucky with their ideas, their precepts, and examples during these early times.

Members of the medical faculty in Lexington, quite early in the 19th century, demonstrated their concern for the welfare of their fellow citizens and the importance of preventive medicine, when Edward Jenner's vaccination against smallpox was introduced there. Drs Samuel Brown, Frederick Ridgely, and Basil Duke vaccinated patients in Lexington in 1802. It has been claimed that more than 500 cases were vaccinated with fresh kinpox from the udder of an infected cow.

In 1837, a new medical school, The Louisville Medical Institute, was chartered and a building constructed in Louisville, a city whose location at the Falls of the Ohio River had resulted in its early growth and development. Medical lectures,¹² however, had been given in Louisville and medical apprentices trained¹³ for almost two decades before the Institute formalizing medical education had been chartered.

For the medical profession to grow, information on its science and art must be disseminated. Quite early in our country, medical information was, as it is today, disseminated in the public press. This is perhaps the manner in which knowledge assuring the ultimate acceptance of such a discovery as successful vaccination for the prevention of smallpox was presented to the public and the profession alike.

There were medical and scientific journals¹⁶ published in the United States prior to 1800; e.g., *Am Philos Soc Trans & Proc* (1769), *Medical Repository* (NY, 1797), but they were certainly not easily acquired on the frontier. By the decade of the 1830s, however, several creditable and more easily acquired journals appeared in the West, e.g., *West Med & Physical J* (Cincinnati, 1827), *Transylvania J Med & Assoc Sc* Lexington, 1828), *Louisville J Med & Surg* (Louisville, 1837), and *West J Med & Surg* (Louisville, 1840). These journals were just the beginnings of medical journalism in the West.¹⁷ They were published by editors who were professors in their respective medical schools, and they served to make the profession

Brief Overview of 200 Years of Medical Practice: Part I

acquainted with their schools, their faculties, and graduates. The journals were financed by subscription only. No advertising appeared in them and no costs were underwritten by the faculty.

As the number of physicians increased in our state, it became increasingly apparent that some unanimity should be attempted concerning the fees that would be charged for their services. The first effort in this direction was put forth in Louisville in February 1819, when a society of 16 physicians published a fee schedule.¹⁸ This was but a first step towards the founding of another medical society on a larger scale and primarily for establishing a code of ethics, promoting projects for improvement of public health, and the continuing education of the physician.

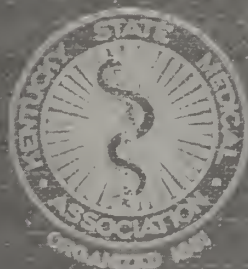
Establishing a statewide medical society was attempted in January 1841, but it did not survive. The effort was revived in 1851 and the Kentucky State Medical Society was successfully established, and it has been functional and beneficial to practitioners throughout the state ever since.¹⁹

This essay will be concluded in another issue.

References

1. By the time Kentucky became a state, it had nine counties [Fayette (1780), Jefferson (1780), Lincoln (1780), Nelson (1781), Madison (1785), Bourbon (1785), Mercer (1786), Woodford (1788), Mason (1789)], and in the same year, the Legislature made six more, Greene, Hardin, Logan, Scott, Shelby, Washington].
- 2a. Draper MSS, 2ZZ 75.
- 2b. Ochterlony JA. Pioneer men and times in Kentucky. *The Am Prac & News* ns 9, 321-332 — 1890, p 325-326.
3. Many physicians practicing in the 18th & 19th centuries had not obtained a medical degree (MD or MB). Some had served as apprentices or had gained experience as military surgeons; others perhaps had no training at all.
4. The author has examined many of our early newspapers, primarily of Lexington & Louisville, for notices of physicians. The first newspaper in Kentucky was the *Kentucky Gazette*, a weekly, which was first printed on 11 August 1787 in Lexington, KY, by John & Fielding Bradford. This newspaper was published until 1848. Various members of the Bradford family published it until 1809 but were owners for brief periods until 1840. Louisville had a newspaper, *The Farmer's Library*, in 1801. The following year a second newspaper, *The Louisville Gazette*, is said to have been established. The *Western Courier* and *Louisville Correspondent* first appeared in 1810, in Louisville.
5. Clarkson Freeman notice of beginning practice in Lexington *Kentucky Gazette* XI. No. 620, 8 August 1798, p 1, col [4].
6. The 'Seminary of Learning,' funded originally by the Virginia Legislature with 8,000 acres of land in Kentucky confiscated from Loyalists and supplemented by the Virginia General Assembly in 1783 with an additional 12,000 acres of escheated lands, had been a pawn of political and religious factions for 18 years and had been located in Lexington and also in Danville as Transylvania Seminary, a grammar school. The Kentucky General Assembly in 1798 consolidated the schools and appointed a new board of trustees for Transylvania University to assure its active function.
7. Frederick Ridgely, MD, by E. H. Conner, MD, *Dictionary of Am Med Biogr.* Edited by M Kaufman, S Galishoff and Todd Savitt, Greenwood Press, Westport CT, 1984, 2, p 638.
8. *Ibid*, 1, Samuel Brown, MD, pp 100-101.
9. "Transylvania University." *The Kentucky Gazette*. 13. No. 693, p 3, col [3], Thursday, 2 January 1800.
10. *Ibid*.
11. Faculty in the 18th & 19th centuries meant members of the medical profession in general and was not necessarily indicative of a formal appointment in a university medical school.
12. *Kentucky Gazette*, Tuesday, 16 August 1803, 16. Letter concerning the Lexington Medical Society, signed by James L. Armstrong, Secretary. Manuscript minutes of this society beginning in 1802 are in Transylvania University: It was prospering in 1828, *Transyl Med J*, 1, 300, 1828.
13. Littell, William, Editor. *The Statute Law of Kentucky*, Frankfort, KY, 1811, 3, p 159 "An Act Authorizing a Lottery for the Benefit of the Lexington Medical Society," Approved Dec 17, 1803.
14. Harrison, John Pollard. *Essays and Lectures on Medical Subjects*. J. Crissy, Philadelphia, 1835. pp 68-83.
15. Conner, E. H. "Chronica Medica Kentuckiensis." *Bull Jeff Co Med Soc* 13, 15, March 1965, and *ibid*, 13, 19, 38, April 1965.
16. Gregory, Winifred, editor. *Union List of Serials in Libraries of The United States and Canada*. 2nd Edition. The H H Wilson Co, New York, 1943.
17. Horine, Emmet F, Daniel Drake and the Origin of Medical Journalism West of the Allegheny Mountains. *Bull Hist Med* 27, 217-235 (May-June) 1953.
18. *Louisville Public Advertiser*, Wednesday, February 24, 1819, 1, p 3, col [5].
19. Horine, Emmet F, Sketch of the Kentucky State Medical Society. *Papers presented before the Ephraim McDowell Memorial Meeting, Centennial of the Kentucky State Medical Assoc.* JG Denhardt, Publ. Bowling Green, KY 1952. xi-xxii.

Papers of the
CENTENNIAL MEETING
of the
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Association



In our two-part bicentennial section, we will reproduce several articles from previous issues of the Kentucky State Medical Journal.

This issue features a reproduction of a paper written for the 1951 Centennial issue of the KSMJ by Emmet F. Horine, MD, giving a detailed early history of our State Society. Dr Horine's paper is a thorough study which has not been duplicated before nor has it been surpassed in quality and detail.

The presidential address of our first President, William Loftus Sutton, MD, and that of Samuel A. Overstreet, MD, who served as President of KMA in 1951-52, will be featured in part two of this section.

— EUGENE H. CONNER, MD
KMA HISTORIAN

SKETCH OF THE KENTUCKY STATE MEDICAL SOCIETY¹

By

Emmet Field Horine, M. D.

Brooks, Kentucky

The earliest association of physicians in Kentucky was doubtless formed in Lexington sometime during the last decade of the eighteenth century. The authorization of a department of medicine by Transylvania University in 1799 and the appointment of two professors, Drs. Samuel Brown (1769-1830) and Frederick Ridgely (1757-1824), had much to do with focusing attention on Lexington as a medical center.² The Board of Trustees did not designate which branches of medicine Brown and Ridgely were to teach. In fact, the Medical Department of Transylvania University was not fully organized and accredited courses did not begin until the fall of 1817 as has been shown elsewhere.³ However, as a result of their appointments Drs. Brown and Ridgely no doubt attracted more private pupils than did other Lexington physicians.

An advertisement of Transylvania University in 1799 stated that "Law and Medical societies meet each week in town. . ."⁴ This announcement was written by a Committee composed of the President, J. Moore; a Trustee, J. Crawford and Dr. Brown.⁵ The advertisement stated that Dr. Frederick Ridgely would teach "Materia Medica, Midwifery and the practice of physick" and that the "important studies of Chemistry, Anatomy, and Surgery are confided to Dr. Samuel Brown." Apparently Drs. Brown and Ridgely had themselves agreed upon the subjects each was to teach. A careful search of the early *Records of the Proceedings of the Board of Trustees* fails to reveal any teaching assignments to them.

The exact date of the organization of the Lexington Medical Society is un-

known. There are in existence casual minutes for meetings during 1803 and 1804. The roster dated 1 October 1803 discloses that there are fifteen "ordinary" members.⁶ Apparently the "ordinary" members were medical students apprenticed to various Lexington physicians, especially Drs. Brown and Ridgely. There were also honorary members, physicians and also laymen in Lexington, and Drs. Charles Caldwell and James Woodhouse of Philadelphia. Benjamin W. Dudley (1785-1870) was one of the early secretaries of the Lexington Medical Society (1804). This was before he had received his degree in medicine from the University of Pennsylvania in 1806.⁷ The following announcement is of interest:

For the promotion of medical and Natural Science, there will be an intermediate meeting of the Lexington Medical Society on Saturday the 16th inst. half past 2 o'clock, at the Transylvania University Hall, where the following subject will be discussed: Is heat material, and the cause of the elasticity of the gases?

*By order of the Committee,
Benj. W. Dudley, sec'y.*⁸

The advertisement of a lottery for the benefit of the *Kentucky Medical Society* (herewith reproduced) would seem to indicate that a state-wide medical organization was in existence in 1804.⁹ This was my original impression but such was not the case. The Legislature of Kentucky on 17 December 1803 approved a lottery for the Lexington, not the "Kentucky," Medical Society.¹⁰ Evidently the managers, in writing the advertisement, failed to use the proper caption. It will be observed that prominent Kentuckians were

1. This was the original name used until 1902, when a revised Constitution and By-Laws were adopted which substituted the word "Association" for "Society."

2. Transylvania University: *Records of the Proceedings of the Board of Trustees* (1799-1810), Vol. I (Second Section), p. 3, January 8, 1799.

3. Emmet F. Horine: *Early Medicine in Kentucky and the Mississippi Valley: A Tribute to Daniel Drake, M. D. Journal of the History of Med. and Allied Sciences*, III:263-278, Spring 1948.

4. [Advertisement]—Transylvania University [dated 24 December 1799.] *The Kentucky Gazette*, XIII, No. 693: p. (3)-c. (3-4), January 2, 1800.

5. Transylvania University: *Records* . . . I (Second Section), p. 49, Dec. 11, 1799.

6. *Minutes of Lexington Medical Society (1803-1804)*, in Library of Transylvania College.

7. *Catalogue of the Medical Graduates of the University of Pennsylvania*. . . 2d Ed. Philadelphia: Lydia R. Bailey, 1839, p. 24.

8. Benj. W. Dudley: [Announcement]—*Kentucky Gazette and General Advertiser* (Lexington), XVII, No. 925: p. (2)-c. (5), June 5, 1804.

9. [Advertisement of Kentucky Medical Society Lottery], *Kentucky Gazette and General Advertiser* (Lexington), XVII, No. 909: p. (2)-c. (5), February 14, 1804.

10. William Littell: *The Statute Law of Kentucky*. . . Frankfort, Ken.: William Hunter, 1811, Vol. III:159.

listed as managers. Among these were John Pope (1770-1845) lawyer, Kentucky Representative, later U. S. Senator from Kentucky and Territorial Governor of Arkansas; Daniel Bradford (d. 1851) publisher of *The Kentucky Gazette*; and Thomas Bodley (1772-1833), prominent Mason, civic leader and member of the Board of Trustees of Lexington.

Lotteries, then legal and widely used for raising money for charitable and other organizations, were no doubt disappointing in their returns except, perhaps, to their promoters. The advertisement of the lottery appears in *The Kentucky Gazette* (Lexington) from the issue of 14 February 1804 through that of 8 May 1804. The drawing which was to have commenced in May was "postponed until 15th September next. . ."¹¹ Careful search of the *Gazette* fails to reveal any further announcement concerning the lottery. Newspapers of the early nineteenth century carried little local news but instead many columns of happenings, months old, in distant parts of the world. Perhaps news of local events was so rapidly disseminated by word of mouth that it was thought to be waste of space to print it.

The Medical Department of Transylvania University, as already stated, was officially opened in 1817. After this event it is apparent that medical meetings became more frequent in Lexington as evidenced by newspaper announcements.

No reference to medical societies elsewhere than in Lexington has been found before 1819 at which time one was organized in Louisville. The society established then was indeed feeble if we are to judge from the fact that there is no further mention of it in the Louisville newspapers available for the period from 1820-1830.¹²

The seal of the Lexington Medical Society reveals that it was incorporated in 1821. Closely connected with it was the "Medical Society of Transylvania University of Kentucky" of which Daniel Drake (1785-1852) was President in 1824. At this time, Drake was Professor of Materia Medica and Medical Botany in Transylvania University and, at the same time, was delivering the lectures on the practice of medicine in the absence of Dr.

Samuel Brown. It is apparent that each graduate of the Medical Department of Transylvania University was awarded a certificate of membership in this society.

600 Dollars for 5!!!

BY AUTHORITY.

SCHEME
or

A LOTTERY

To build a house for the *Kentucky Medical Society*, in the town of Lexington.

FIRST CLASS.

SCHEME.

Prizes	of Doll.	is Doll.
1	600	last drawn ticket, 600
2	250	500
4	100	400
10	50	500
20	20	400
40	10	400
200	6	1200

277 Prizes.
523 Blanks.

Dollars 4000

800 Tickets at 5 Dollars is Doll. 4000

THE laudable object of this Lottery—the valuable Prizes offered (there not being two blanks and a half to a Prize) are considerations which excite a well grounded hope in the managers, that the sale of the tickets will be rapid. The drawing will commence on the first Monday in May next, and thirty days after the completion of the drawing, the Prizes will be paid to the fortunate adventurers, subject to a deduction of 15 per cent. Such prizes as shall not be demanded within twelve months after the drawing is finished, shall be considered as relinquished for the benefit of the Society. For the satisfaction of the purchasers, it may be necessary to mention, that the managers have given a bond for the due payment of the prizes that may be drawn. Tickets to be had of the managers.

John Pope,
Thos. Wallace,
Geo. Trotter, jun.
Danl. Bradford,
Jas. Fishback,
Andrew M'Calla,
Thos. Bodley,

Managers.

11. [Medical Society Lottery.] *Kentucky Gazette and General Advertiser* (Lexington), XVII, No. 923: p. (3)-c. (5), May 22, 1804.

12. *Daily Louisville Public Advertiser*, Vol. I. No. 58, April 28, 1819 through December 31, 1830.

In reality the Medical Society of Transylvania University seems to have been a medical alumni association, unquestionably the first alumni organization west of the Allegheny Mountains.

The "Athens of the West," as Lexington was often called at this time, produced two other societies which deserve mention. The "Medico-Chirurgical Society of the Academy of Medicine of Kentucky" may have been sired by the indefatigable polemist, Charles Caldwell (1772-1853). This society issued an ornate certificate of membership in Latin. On it was a portrait of Caldwell with flowing beard. Under the portrait was the inscription: "Father of western medicine."¹³ His delight over this may be readily surmised when it is recalled that once in lecturing he announced that, to his knowledge from the standpoint of phrenology, there were but three perfect heads in America, that of Henry Clay, that of Daniel Webster but modesty forbade that he name the third.

The "Kappa Lambda Society of Hippocrates," a secret medical fraternity with imposing initiation ceremonies was founded in 1820 by Dr. Samuel Brown, Professor of the Theory and Practice of Medicine at Transylvania University. The ideals of this society were to promote science, friendship, virtue and honor. This organization deserves more than passing notice because of its influence in elevating medical standards and its establishment of affiliated chapters in several of the larger eastern cities especially Philadelphia, New York and Baltimore. At first no Kappa Lambda chapter could be started without a charter from the parent one in Lexington. Later it was found expedient to designate the first affiliate in any state as the "Grand Kappa Lambda Society" for that state with authority to issue charters in the area under its jurisdiction.¹⁴

With the exception of Drs. Benjamin W. Dudley and Charles Caldwell, the professors of Transylvania's school of medicine joined with Dr. Brown in his endeavors. The Lexington chapter existed approximately ten years.

In Philadelphia, the influence of Kappa Lambda was for awhile extremely salu-

tary. Dr. Rene La Roche (1795-1872) of Philadelphia describes the effect of Kappa Lambda as follows:

*[The medical men in Philadelphia] lived in an almost constant state of warfare,—quarreling, and even worse, was not uncommon among them, and now and then street fights occurred. This state of things gave way under the influence of the society. Soon after its establishment, harmony, comparative harmony, at least was restored among its members, and before long, through their influence, among other medical men around them. The society did more. At its meetings much was done to excite emulation among its members, and to promote the advancement of medical science. . . .*¹⁵

A periodical, *The North American Medical and Surgical Journal* (Philadelphia), was started at the suggestion of Dr. Brown under the auspices of the Kappa Lambda Society. It was continued through twelve volumes, January 1826-October 1831. With its own publication and with the establishment of many active chapters, the society seemed destined to exert a beneficial influence for all time. However, the fact that Kappa Lambda was a secret organization led to violent opposition, notably in New York, in the eighteen-thirties.¹⁶ Despite the attacks, the New York chapter survived, sent delegates to the early meetings of the American Medical Association and is known to have been active as late as 1862.¹⁷

With the increasing number of physicians in Kentucky, the need for a statewide organization became more apparent and, in 1839, the Medical Association of Northeastern Kentucky, meeting in Washington, adopted the following resolutions:

That this Association respectfully urge upon physicians of Kentucky, the expediency of forming district and county societies, for the promotion of medical science; and also, that a State

15. R. La Roche: Samuel Brown [in] Samuel D. Gross: *Lives of Eminent American Physicians and Surgeons*. Philadelphia: Lindsay & Blakiston, 1861, p. 245.

16. *A History of the New York Kappa Lambda Society*. New York: William Stuart, 1839.

17. Philip Van Ingen: Remarks on Kappa Lambda, Elf or Ogre? and a Little More Concerning the Society. *Bulletin of History Med.* (Baltimore), XVIII:513-538, December 1945. Anyone interested in learning more about Kappa Lambda may consult the following articles which, however, appear somewhat prejudiced: Chauncey D. Leake: What was Kappa Lambda? *Annals of Medical History* (New York), IV:192-206, June 1922; Lee D. Van Antwerp: Kappa Lambda, Elf or Ogre? *Bull. Hist. Med.* (Baltimore), XVII:327-350, April 1945.

13. A. H. Barkley: *Kentucky's Pioneer Lithotomists*. Cincinnati: C. J. Krebbel & Co., 1913, p. 135.

14. Henry Miller: *Resolutions at a Meeting of the Kappa Lambda Society of Hippocrates*. . . Dec. 11, 1822. [Broadside, Lexington, 1822.]

*Convention be held in Frankfort, on the second Monday in January, 1841, for the purpose of organizing a State Medical Society.*¹⁸

Pursuant to this recommendation, a group of sixty-nine physicians met in Frankfort on 11 January 1841. Thirty-nine counties were represented. The "State Medical Society of Kentucky" was established and the following officers were elected: President, Dr. Burr Harrison of Bardstown; Vice-Presidents: James C. Cross, Lexington and John A. Tomlinson of Mercer County; Secretary, D. H. Dickinson of Frankfort. Later, Dr. N. T. Marshall of Maysville was appointed Corresponding Secretary. A comprehensive constitution and by-laws with a section on medical ethics were approved. Resolutions concerning improvements in medical education were passed in addition to a consideration of much routine business.¹⁹

No scientific program had been arranged but, by request, Dr. James C. Cross (1798-1855) delivered a discourse on *Geology* and Dr. Daniel Drake one entitled, *A Memoir on the Diseases Called by the People "Trembles," and the "Sick-Stomach" or "Milk-Sickness."*²⁰ This latter paper was a carefully prepared original investigation of a local malady. This essay has attracted much interest over the years. Its inclusion by Fielding H. Garrison in the list of important texts illustrating the history of medicine is evidence of its importance.²¹

Despite such an auspicious organizational meeting and the fact that the second, scheduled for 12 January 1842, in Frankfort was given publicity in *The Western Journal*. . . not enough physicians for a quorum came at the appointed time.²² The failure to carry on is the more deplorable as the by-laws designated only twenty as a quorum. It is a sad commentary on the officers that not a single one was present, not even the Recording Secretary whose home was Frankfort.

18. Daniel Drake (Editorial): Medical Convention of Kentucky. *Western J. of Med. and Surgery* (Louisville). II:480-481, Dec. 1840.

19. *Journal of the Proceedings of a Convention of the Physicians of Kentucky Held in Frankfort the eleventh day of January 1841*. Frankfort, Ky.: A. G. Hodges, 1841.

20. Daniel Drake: A Memoir on the Diseases called by the People "Trembles" . . . *Western J. Med. and Surg.*, (Louisville), III:161-226, March 1841. Also separately issued in 1841 by James Maxwell, Jr.; Louisville, Ky., pages 57.

21. [Fielding H. Garrison]: Texts Illustrating the History of Medicine in the Library of the Surgeon General. *Index-Catalogue S. G. L.*, 2d Series, XVII:143, 1912.

22. Daniel Drake: (Editorial), *West. J. Med. and Surg.* (Louisville), V:79, Jan. 1, 1842.

Drs. Samuel D. Gross and Daniel Drake of Louisville waited about for half the day when they left for Lexington to visit friends. Later in the day, as stated by J. C. V. Smith, Editor of *The Boston Medical and Surgical Journal*:

. . . Quorum or no quorum, a few distinguished medical gentlemen organized themselves, chose a chairman and secretary, and then listened to some spirited resolves—one of which was this—'That the interests of the medical profession and the public in general, would be promoted by the establishment of a board of examining physicians, who shall meet annually for the purpose of conferring diplomas on all candidates who may be found worthy on a rigorous examination.' Dr. Duke read a paper on medical education. . . [It was agreed that a circular letter be issued imploring Kentucky physicians to reconvene at Frankfort.] The meeting, therefore, was adjourned, sine die. . .²³

There is no record of any subsequent effort to vitalize the 1841 organization.

It was not until 1 October 1851, that another group of physicians, numbering thirty-nine, convened at Frankfort for the purpose of organizing a state medical association. The group assembled in the Senate Chamber at 10:00 A. M., with Dr. William Loftus Sutton of Georgetown, in the Chair, and Drs. E. H. Watson and J. M. Mills of Frankfort, secretaries. A second session of the convention was held at 2:30 P. M. at which time the Kentucky State Medical Society was organized and the following officers were elected:

President, W. L. Sutton, Georgetown.

Senior Vice President, W. S. Chipley, Lexington.

Junior Vice President, J. Dudley, Nicholasville.

Recording Secretary, W. C. Sneed, Frankfort.

Corresponding Secretary, R. J. Breckinridge, Jr., Louisville.

Treasurer, R. W. Glass, Shelbyville.

Librarian, Ben Monroe, Frankfort.

After a short recess the first annual meeting of the Society was held, the *Proceedings* of which are herewith reproduced. No copies of these *Proceedings* were known until several were found in

23. J. C. V. Smith: Medical Circular in Kentucky. *Boston Med. and Surg. J.*, XXVI:210, May 4, 1842.

TRANSACTIONS

PROCEEDINGS

OF THE

FIRST ANNUAL MEETING

OF THE

STATE MEDICAL SOCIETY OF KENTUCKY.

OF THE

FIRST ANNUAL MEETING

OF THE

KENTUCKY STATE MEDICAL SOCIETY,

HELD IN THE CITY OF FRANKFORT,

ON THE FIRST DAY OF OCTOBER, 1851.

FRANKFORT, KENTUCKY.

A. G. HODGES & CO., PRINTERS.
1851.

the attic of a house about to be torn down at Churchill Downs (Louisville).²⁴

Shortly after the meeting in 1851, an application for incorporation of the Kentucky State Medical Society was made. This was favorably acted upon by the General Assembly and the Society was duly incorporated on 24 November 1851.²⁵ One interesting section of the Act which so far as I know has never needed to be enforced is the following:

3. *That it shall be lawful for said society to require of persons admitted to membership therein, such admission fees and annual contributions as a legal quorum thereof may, from time to time, enact; and if any member shall refuse or fail to pay such admission fee or annual contribution, the same shall be recoverable by the society, on motion, with ten days notice, before any of the superior or inferior courts of law held in this Com-*

24. Emmet P. Horine: *A Collector Goes to the Race Track Bookishly Inclined. The Filson Club History Quarterly* (Louisville) XVIII:203-223, October 1944.

25. *Acts of the General Assembly of the Commonwealth of Kentucky passed at November Session, 1851, Frankfort, Ky.: A. G. Hodges & Co., 1852, pp. 375-376.*

At the first annual meeting of the State Medical Society of Kentucky, held in the Senate Chamber at Frankfort, on the 1st day of October, 1851, at 5 o'clock, P. M., the President, Dr. W. L. SUTTON, took the chair, and called the Society to order.

On motion of Dr. Ayres, a committee, consisting of Drs. Dudley, Yandell, Harrison, Roberts, and Winston, was appointed to apply to the next meeting of the Legislature for a charter for the Society.

On motion of Dr. Chipley, the next annual meeting of the Society was ordered to be held in the city of Louisville, on the third Wednesday in October, 1852.

On motion of Dr. Richardson, it was
Resolved, That the Code of Medical Ethics of the American Medical Association be adopted as the Code of this Society.*

Dr. Chipley presented a form of charter for the Society, which, after some discussion, was withdrawn.

On motion of Dr. Breckinridge, a committee, consisting of Drs. Rodman, Anderson, Thomson, Ayres, and Spillman, was appointed to draft a set of by-laws.

The application of Dr. J. C. Darby, of Lexington, was received for membership, and then the Society adjourned until half past 7 o'clock.

HALF PAST 7 O'CLOCK, P. M.

The society was called to order by the President.

The application of Dr. Darby was taken up, and he was duly elected a member of the Society.

The President announced the appointment of the following gentlemen as Chairmen of the various standing committees, each Chairman having the liberty to select two others as associates:

Chairman of Committee of Arrangements—DR. ANDERSON—DRS. BRECKINRIDGE and W. H. MILLER, *Associates*.

Chairman of Committee on Improvements in Practical Medicine—DR. FORCE—DRS. RODMAN and RICHARDSON, *Associates*.

* See Code of Ethics, page 13.
† Up to the time of the proceedings going to press, the Chairmen of several of the committees had not handed in the names of their associates.

6

Chairman of Committee on Improvements in Pharmacy—DR. MILLS—DRS. GORE and RAT, *Associates*.

Chairman of Committee on Vital Statistics—DR. CHIPLEY—DRS. YANDELL and DUDLEY, *Associates*.

Chairman of Committee on Obstetrics—DR. H. MILLER—DRS. SNEED and LETCHER, *Associates*.

Chairman of Committee on Medical Ethics—DR. A. EVANS.

Chairman of Committee on Public Hygiene—DR. E. C. DRANE.

Chairman of Committee on Epidemics—DR. DARBY.

Chairman of Committee on Improvements in Surgery—DR. GROSS.

Chairman of Committee on Indigenous Botany—DR. SPILLMAN.

Chairman of Committee on Finance—DR. THOMSON.

On motion of Dr. Breckinridge, the President was appointed Chairman of a committee to memorialize the Legislature upon the subject of registration of marriages, births, and deaths.

The committee on by-laws were granted until next regular meeting of the Society to report.

On motion of Dr. Breckinridge, the Society determined to go into the election of honorary members. The vote was reconsidered, and the subject for the present postponed.

The Society elected the following persons as delegates to the next annual meeting of the American Medical Association, viz: Drs. L. G. Ray, E. D. Force, T. G. Richardson, D. J. Ayres, D. S. Slaughter, E. C. Drane, W. H. Miller, W. R. Evans, and Joshua Gore.

A series of resolutions were offered by the President, Dr. Sutton, which were laid over until the next regular meeting.

The Secretary and Treasurer were required to give bonds in the sum of two hundred dollars, each, for the faithful performance of their respective duties.

On motion of Dr. Gross, the President was requested to deliver an opening address at the next annual meeting of the Society.

The Society recommended the formation of County Medical Societies.

The record of proceedings was read, and after slight amendments, was adopted, and ordered to be published in connection with the Constitution and Code of Medical Ethics.

A vote of thanks was tendered the officers of the Society for the prompt and efficient manner in which they discharged their respective duties, and

The Society adjourned. W. L. SUTTON, *President*.

W. C. SNEED, *Secretary*.

NOTE.—Owing to the limited time in which the notice for the call of the Convention was issued, the attendance was comparatively small, but, as will be observed from the proceedings, the Society may now be regarded as constituted upon such a permanent basis as will tend to the elevation of the profession, and a more zealous and harmonious co-operation in accomplishing its legitimate objects.

All regular surgeons and physicians in the State are requested to unite with the Society, on the terms prescribed by the Constitution, and forward their applications, prepaid, to Dr. W. C. SNEED, Recording Secretary, Frankfort.

Several applications have already been received since the adjournment.

Particular attention is requested to the Code of Ethics.

monwealth, or in any county, city, or corporation whereof the member, so refusing or failing to pay, shall be an inhabitant.²⁶

A summary of the proceedings of the second annual meeting is as follows:

At the second annual meeting of the State Medical Society, held in the Circuit Court room, in Louisville, on the 20th day of October, 1852, at 1 o'clock P. M., the President, Dr. W. L. Sutton took the chair and called the Society to order.

Dr. Gross moved to call the roll of members, when the following were found to be present: N. B. Anderson, R. J. Breckinridge, W. S. Chipley, W. R. Chew, J. Dudley, E. C. Drain, J. C. Darby, A. Evans, J. B. Flint, E. D. Foree, S. D. Gross, W. H. Miller, J. P. Letcher, Henry Miller, T. G. Richardson, W. L. Sutton, W. C. Sneed, C. H. Spilman, D. D. Thompson.

Various members proposed candidates for membership numbering in all forty-six, Dr. Henry Miller seconding the whole list. . .²⁷

The meeting was an active one and in addition to the presidential address, eight special committee reports were presented on the following subjects: *vital statistics, medical ethics, obstetrics, registration, surgery, indigenous botany, epidemics, and case book.* These were published in 1853 along with the minutes of the meeting to make a volume of 332 plus xii pages. The thoughtful address of President Sutton dealt with many matters of importance even today. Because of this and the fact that it was the first presidential address, it seems fitting to include it in this Centennial Volume (p. xxx.)

During the 1852 meeting, the first honorary members were elected namely, Daniel Drake, M. D. of Cincinnati, Ohio; Elisha Bartlett, M. D. (1804-1855) of New York, and "Dr. Deaderick, of Tenn." The last named has been positively identified as Dr. William H. Deadrick (1773-1858) of Athens, Tennessee, who in 1810 removed a portion of the submaxillary bone for exostosis.²⁸

Five years before our initial meeting

26. *Ibid.*

27. *Transactions of the Kentucky State Medical Society, at their meeting, held in Louisville on the third Tuesday of October, 1852.* Louisville, Ky.: Webb & Levering, 1853, p. 5.

28. [Samuel D. Gross]—*North American Medico-Chirurgical Review* (Philadelphia). 11:205, Jan. 1858.

the first successful public demonstration of the use of anesthetics in a surgical operation was made in Boston, Massachusetts, on 16 October 1846. Had the full implications of this epoch-making event been recognized, a special report on anesthesia no doubt would have been included in the first program. It is true, Dr. Henry Miller (1800-1874) discussed the great value of anesthesia in obstetrical work before the 1852 meeting, but Dr. Samuel D. Gross, in the extensive report of the Committee on Surgery, ignored the subject.²⁹

In commenting on the third annual meeting (October 19-21, 1853) of the Association, Dr. Lunsford P. Yandell, Sr. (1805-1878) wrote as follows:

*The Third meeting of the Society was held, in October last, at Lexington, but although great preparations had been made by the physicians of that city for the reception of the Society, and though the committees appointed to make reports had been industrious in preparing for their duties, the attendance was small. The meeting was a spirited one, and the reports read were elaborate and thorough; but the state of the Treasury, owing to the small number of members present, is such that the Proceedings are not likely to be published. It is feared that the first volume which elicited so much praise and was regarded by the Society with such just pride, will also be the last. This is not worthy of the profession of Kentucky. We had expected a different result. The beginning was so spirited, so full of promise, that we had counted on seeing the Society go on from year to year growing in fame and usefulness, extending its researches, developing the medical history of the Commonwealth, and animating the members of our profession with a livelier zeal for its advancement. We still hope that new energy will be infused into it, and that we shall yet see it successfully pursuing its high mission.*³⁰

An interesting sidelight of the 1853 meeting was a motion made by Dr. Spilman that "in the future no Chairman of a Special Committee shall occupy more

29. *Transactions.* . . 1852. Pp. 99-290.

30. Lunsford P. Yandell [Editorial]: *Kentucky Medical Society. West. J. of Med. and Surg.* (Louisville) New Series 1:224-225, March 1854.

than an hour and a half in reading his report." Perhaps Dr. Spilman had in mind the Report on Surgery by Dr. Samuel D. Gross given in 1852. It comprised over one hundred and ninety printed pages and must have required many hours for its presentation!

Possibly because of the poor attendance at fall meetings, Dr. Gross in 1854, offered a resolution to the effect that future meetings be held in "Frankfort on the first Wednesday in February of each year."³¹ This was passed and no meeting was held in 1855. However, the fifth meeting was convened at Frankfort on 6 February 1856. The proceedings of this meeting were published³² though those of the third and fourth meetings were never printed. The transactions for 1856 contained the address of the President, Dr. Charles H. Spilman, as well as several interesting reports. One especially was "on the best means of expediting the collection of medical bills and improving the finances of the medical profession."³³ The roster showed a membership of 187. The newly elected President, Dr. W. C. Sneed, who had been Recording Secretary since the Society began suggested that an assessment of three dollars from every member be made to defray the cost of publication of the transactions for 1853 and 1854.³⁴ This suggestion was evidently not acted on.

The last meeting before the Civil War was held in 1860 at Bardstown under the presidency of Dr. Cyprian Peter Mattingly of that place. Dr. Benjamin Rush Palmer of Louisville was elected President and Owensboro designated the place of meeting for 1861. Wide search of the newspapers and medical journals covering the period has failed to reveal evidence that a meeting was held either in 1861 or at any subsequent time until 21 April 1867 when the Society was reorganized at Louisville.

Dr. Palmer who had been elected President in 1860 died in 1865 and, at the reorganization meeting, "Dr. Lewis Rogers was called to the chair, and Dr. Owen appointed Secretary for the temporary

meeting."³⁵ Only a few of the original members were present, such as Drs. L. P. Yandell, Sr., Llewellyn Powell, W. Talbot Owen and George W. Bayless. The following were the unanimously elected officers:

D. N. Porter, of Eminence, *President*.

John F. Lewis, Carrollton, *Senior Vice-President*.

C. L. Jones, Harrodsburg, *Junior Vice-President*.

P. B. Scott, Louisville, *Recording Secretary*.

W. Talbot Owen, Louisville, *Corresponding Secretary*.

W. H. Newman, Louisville, *Treasurer*.

J. F. McElroy, Lebanon, *Librarian*.

Drs. D. W. Yandell, of Louisville, S. P. Breckinridge, of Danville, and George Beeler, of Clinton, *Committee on Publication*.

The meeting of 1868 was held in Lebanon and, according to the *Transactions*, was called the "Thirteenth" but available records disclose this to have been incorrect. Meetings had been held during the following years: 1851, 1852, 1853, 1854, 1856, 1857, 1858, 1859, 1860 and 1867. Therefore, the Lebanon meeting was not the "thirteenth" but the *eleventh*.

The most significant subject brought before the meeting in Lebanon was *The Inoculability and Transmission of Tuberculosis* in a report presented by Dr. John D. Jackson of Danville.³⁶ He reviewed the brilliant inoculation experiments of Jean Antoine Villemain (1827-1892) which proved that tuberculosis was a specific and transmissible infection. Unfortunately, Jackson did not admit of the validity of the experiments which reveal clearly the difficulty experienced by discoverers in having their work accepted. Bacteriology had its inception in the investigations of Leeuwenhoek who described bacteria in 1676 and utilized incubation in their study. However, almost two hundred years elapsed before the discoveries of Pasteur and Koch laid the foundation for the giant strides in bacteriology which have occurred during our first century.

Unfortunately space does not permit a review of many worthwhile reports and essays which were read before the organization. The *Transactions* from 1868

31. [Report of Proceedings]—Kentucky State Medical Society. *West. J. Med. and Surg.*, N. S. II:367, November 1854.

32. Kentucky State Medical Society: *Transactions of the Fifth Annual Meeting . . . held in the City of Frankfort on 6 and 7th of February 1856*. Frankfort: A. G. Hodges, 1856.

33. *Ibid.*, pp. 35-44.

34. *Ibid.*, p. 65.

35. *Proceedings of the State Medical Society of Kentucky*. Meeting for reorganization, April 2 and 3, 1867 and the Thirteenth Annual Meeting, April 7 and 8, 1868. Cincinnati: Robert Clarke & Co., 1868, p. 4.

36. *Ibid.*, pp. 64-81.

through 1878 were quite interesting varying in length from 41 pages (1870) to 263 in 1874. No doubt the size of the volumes varied in ratio to the bank balances of the Society. The financial status must have been considerably reduced during the period from 1879 through 1891 since there were published merely the minutes and occasionally the presidential address.

In 1891 after much debate it was voted to resume publication of a volume of transactions.³⁷ A motion to increase the dues from three to five dollars, for this purpose, was lost. However, in 1892 the Society issued a pretentious volume of 340 pages, the largest since that of 1852.³⁸ In referring to the 1892 meeting as the "thirty-seventh" the error previously mentioned was continued. Actually this was the *thirty-fifth* meeting. The most interesting paper in the volume is that by Dr. Simon Flexner (1863-1946), *The Etiology of Croupous Pneumonia*. This received the Joseph Benson Marvin (1852-1913) award of Fifty Dollars.³⁹ It is of interest to record the fact that after graduation from the University of Louisville School of Medicine in 1889, Dr. Simon Flexner was elected to membership in our Society. In 1890, he gave a report on *Pathological Histology and Urinalysis*, probably the first of his many medical papers.⁴⁰ The following year, Dr. Flexner read an essay entitled *The Diagnostic Value of the Diphtheria Bacillus*.⁴¹ He at no time engaged in the practice of medicine.⁴² From Louisville Dr. Flexner went to Baltimore to work in the laboratory of Dr. William H. Welch (1850-1934) and to continue his chosen career as an experimental pathologist and bacteriologist.

In 1892, the roster of the Society revealed a membership of 412. The *Transactions* for 1892 were followed by equally pretentious volumes, bound in blue cloth, for 1893, 1894, 1895, 1896, and 1897. By that time, the Society was nine hundred dollars in debt and only the minutes and the roster were issued in 1898. Through

this economy, the finances improved and bound volumes were issued in 1899, 1900, 1901 and 1902.

The Society in 1903 decided to discontinue the annual volume and, instead, publish a monthly *Bulletin*. The first issue of this periodical appeared in June 1903 under the editorship of Dr. James B. Bullitt of Louisville. He was also Secretary. Dr. Bullitt devoted much time, effort and imagination to the *Bulletin* which was published in Louisville. As a result of its success, the Council authorized its continuance. At the suggestion of Dr. Steele Bailey, the name was changed

THE KENTUCKY MEDICAL JOURNAL



Being the Journal of the Kentucky State Medical Association.

Succeeding the "Bulletin"
Published Monthly under auspices of the Council
Editorial and Business Office: 205 West Broadway
Subscription Price: \$1.00

to *Kentucky Medical Journal*. The initial issue under the new name appeared in June 1904 as Volume II, No. 1, at which time the Editor wrote in part as follows:

It will be remembered that the publication was begun a year ago in some fear and trembling, as something of an experiment. A year's experience makes the editor confident that the publication can be made a success, from both the standpoint of a medical publication and as a business proposition. . .

The editors of the Journal propose to make it the best medical journal which is, or can be published in the State of Kentucky. There is absolutely no reason why this should not be done. No other journal published in the State of Kentucky can ever have the same backing which the Journal of the State Association has, and, therefore, it is simply a question of intelligent industry as to whether or not the goal above set forth can be reached.

In order to further this object the assistance of Dr. J. A. Flexner, in the department of General Medicine, Dr. Irvin Abell, in the department of General Surgery, and Dr. A. O. Pfingst, in the special departments of Ophthalmology, Laryngology, Rhinology, and Otology has been secured, and these gentlemen will serve as as-

37. [Minutes]—*Thirty-sixth Annual Meeting of the K. S. M. S.* Louisville: John P. Morton & Co., 1891, p. 10.

38. *Transactions of the Kentucky State Medical Society*, New Series, Vol. I. Thirty-seventh Annual Meeting held at Louisville, May 4, 5 and 6, 1892. Louisville: John P. Morton & Company, 1892.

39. *Ibid.*, pp. 147-160.

40. *Minutes of the Thirty-fifth [sic] Annual Meeting of the Kentucky State Medical Society*, May 14-16, 1890. Stanford, Ky.: The Interior Journal Steam Job Rooms, (1890), p. 7.

41. *Ibid.*, Meeting, May 27-29, 1891. Louisville: John P. Morton & Co., 1891, p. 12.

42. Abraham Flexner, TLS to the Editor, 27 November 1931.

SKETCH OF KENTUCKY STATE MEDICAL SOCIETY

sociate editors in the respective departments mentioned. . .⁴³

The extent to which Dr. Bullitt's prophecy has been fulfilled through the years is too well known to require comment. The Kentucky State Medical Association preceded all other states in establishing its own medical journal with the exception of New York, Pennsylvania, Michigan, Illinois, Kansas, Colorado and California.⁴⁴

In 1901 the by-laws were changed and provision was made for the delivery of an oration in medicine and one in surgery. Therefore, at the Paducah meeting in May 1902, Dr. John A. Lewis of Georgetown was elected Orator in Surgery and Dr. John G. Cecil of Louisville, Orator in Medicine.⁴⁵ Since then this custom has been continued and the orations delivered at the Centennial will be found elsewhere in this volume.

The Semi-centennial meeting of the Association was not held until Oct. 18-20, 1905 at the Galt House in Louisville.⁴⁶ By this time the membership numbered approximately 1300. The Oration in Surgery was delivered by Dr. Louis Frank and that in medicine by Dr. Julian T. McClymonds of Lexington.

At the Owensboro meeting, October 10-12, 1906, the Secretary-Editor, Dr. James B. Bullitt (Louisville) was succeeded by Dr. Arthur T. McCormack of Bowling Green. In the November 1906 issue of the *Journal* appeared the parting editorial: *Ad Valedicendum*, of Dr. Bullitt, of which the following is an extract:

With the present issue the editorship of the Journal passes into other hands, those of the new State Association Secretary.

Born, three years and a half ago, the Journal's first, halting steps were taken with pain and difficulty. Since that time it has gradually accumulated strength through experience until today it stands forth in more virile form, the mirror of Kentucky medicine. Good or bad, excellent or indifferent, it is and must always remain what Kentucky doctors are and what they make it.

To the new Secretary-Editor a most cordial greeting is extended with all good wishes for his success in preserving and stimulating an interest in organization work, and perfecting and rendering more useful and helpful the Kentucky Medical Journal. The native talents and abundant energy of the new Secretary-Editor insure the realization of those good hopes.

The Kentucky Medical Journal conceived the idea of and brought into existence the American Association of State Medical Journals. . .⁴⁷

The editorial office and place of publication were moved from Louisville to Bowling Green. The Times-Journal Publishing Company was selected to publish the JOURNAL and has continued in this capacity to the present. The first issue of the JOURNAL to appear under the editorship of Dr. Arthur T. McCormack was that of December 1906.

The JOURNAL was continued as a monthly until April 1909 when it became a semi-monthly.⁴⁸ At that time the Jefferson County Medical Society met four times each month and wished to have published most of the essays presented. An arrangement was made by which this Society agreed to secure annually \$2400 in advertising for which a "Jefferson County Number" of the *Kentucky Medical Journal* was to be published on the fifteenth of each month. This special issue was supervised by an editorial board and a group of associate editors, all members of the Jefferson County Medical Society. The first issue of the JOURNAL sponsored by this group appeared on April 15, 1909. The last "Jefferson County Number" to appear was that for 15 January 1915, after which the JOURNAL again became a monthly.

Dr. Arthur Thomas McCormack was Secretary-Editor of the JOURNAL of the Kentucky State Medical Association for almost thirty-seven years until his death on 7 August 1943. He was succeeded by Dr. Philip Blackerby who continued in office until his accidental death on 24 June 1948. Our present Secretary-Editor, Dr. Bruce Underwood, was then elected. The JOURNAL was in its forty-ninth volume

43. James B. Bullitt, Editor, *Kentucky Medical Journal* (Louisville). II:16, June 1904.

44. *Ibid.*, II:121-122, 206.

45. *Transactions of the Kentucky State Medical Association*. . . Louisville: John P. Morton & Co., 1902. N. S. X:199.

46. *Kentucky Medical Journal* (Louisville), III:597-598.

47. James B. Bullitt: *The Kentucky Medical Journal* (Louisville) IV:1020, November 1906.

48. Arthur T. McCormack (Editorial): The JOURNAL to become a Bi-monthly [sic]. *Kentucky Medical Journal* (Bowling Green) VIII:243 (should have been page 245), April 1, 1909.

at the time of our Centennial. The prophecy made by its first editor, Dr. James B. Bullitt, "that the publication can be made a success, from both the standpoint of a medical publication and as a business proposition" has been amply fulfilled.

From the beginning of our Society wives occasionally accompanied their husbands to the meetings especially if there were relatives in the convention city. Of course when meetings were held in the larger cities, there were such attractions as sightseeing and shopping. It is strange that over the years there were no organized efforts to solicit the aid of the women in our medical activities. As woman's role in society broadened from the exclusive field of the home, it was but natural that activities to further the cause of medicine were conceived. Woman's auxiliaries had been fairly active in some states such as Minnesota, Oklahoma, South Dakota and Texas but it was not until 1922 that the Woman's Auxiliary of the American Medical Association was founded. Following such lead, the Woman's Auxiliary of the Kentucky State Medical Association was organized in 1923 and held its first annual meeting with us at Louisville in 1924. Since then meetings have been held regularly with active and helpful programs. In addition to many constructive projects which concern health the Auxiliary has a McDowell Home Committee which is energetically engaged in completely refurnishing and endowing the residence of Ephraim McDowell (1771-1830) as a national shrine. As time goes on the importance and influence of the Auxiliary will unquestionably expand.

We are fortunate in having portraits of all our past presidents. Our thanks are tendered to Dr. Lillian South for her indefatigable work in securing these portraits. Several were located by her only after years of patient search. The Association has been much less fortunate in its attempt to locate portraits of the past secretaries as will be observed by comparing those on page XL with the list of those who have held this office (page xxxviii). It will be noted that in the earlier years both recording and corresponding secretaries were elected. It is probable that the corresponding secretaries had few duties, judging by the report of one of them, Dr. Joseph N. McCormack (1847-1922), made in 1881:

I have the honor to inform you that I have found nothing to do, as your Corresponding Secretary, during the past year, and have found this condition of affairs, in every way suited to my taste and inclination.⁴⁹

In 1889, a "Permanent Secretary," Dr. Steele Bailey, was elected with an assistant, Dr. John Young Brown. The following year Dr. John Y. Oldman was made assistant to Dr. Bailey. After this, Doctor Bailey was elected *Permanent Secretary*, a position he held until 1903 when he was succeeded by Dr. James B. Bullitt.

The first century of our Association has seen spectacular achievements in every branch of medicine. To cover the many essays found in the programs would require much more space than is at our disposal. The most comprehensive report on surgery ever presented before our Association was that made by Dr. Samuel D. Gross in 1852. It remains for one of our surgeons to review the past century of Kentucky surgery as Gross did for the preceding era. Modern surgery, born when anesthetics were first employed, exhibited only a stunted growth until Joseph Lister (1827-1912) in 1865 began epochal work in antisepsis. Once his principles were firmly established, progress in surgery was so accelerated that today we witness the safe invasion of every cavity of the body, including successful operations on the heart itself. The work of Lister was first presented before our Association at the 1869 meeting: *The Antiseptic Treatment in Surgery* by Dr. Thomas E. Jenkins.⁵⁰

Surgery, like many other fields of medicine, has profited immensely from the discovery of the x-rays by the German physicist, William Konrad Roentgen (1845-1923), in 1895. At first thought to be useful only for locating dense foreign bodies and the presence of fractures, x-ray techniques have been developed to a point where they are employed in almost every special field either for diagnosis or treatment, and frequently for both. Just one year after Roentgen's announcement, the subject was brought to the attention of our Association by Dr. Samuel E. Woody of Louisville. His remarks "were

49. *Minutes of the Twenty-sixth Annual Meeting*. . . April 5-7, 1881, Louisville: Courier-Journal Job Rooms Print, 1881, p. 3.

50. Thomas E. Jenkins: Report of the Committee on Pharmacy. *Proceedings*. . . at Meeting held at Lexington. . . Louisville, Ky.: Bradley & Gilbert, 1869, p. 88.

SKETCH OF KENTUCKY STATE MEDICAL SOCIETY

illustrated by experiments and stereoptican views."⁵¹ It is an interesting coincidence that the discovery of radium followed so shortly, three years, after that of the x-rays. With radium there was an even longer lag than with x-rays between the announcement of the discovery and its practical use.

Hypodermic needles, though used in the eighteen-forties, were not generally employed until long after our Association was organized. In 1851, clinical thermometers were occasionally used but their wide acceptance came several decades later. Although the blood pressure instrument was devised by von Basch in 1887, it was not adopted in the clinic until within my own memory. In fact, it was my privilege to present the first essay on blood pressure observations to be published in our JOURNAL.⁵² Dozens of other instruments have been introduced into the clinic during the past fifty years, including the electrocardiograph, bronchoscope, cystoscope, gastroscope, encephalograph, etc.

The physicists have ushered us into the atomic age with potentialities which intrigue the imagination. Even in the early stages of this new branch of physics, medicine is profiting by nuclear fission of the atom and we cannot begin to guess what future vistas may open to medical science. In the seventeenth century Leeuwenhoek, with his simple lenses, saw objects never before seen. Today, we observe a parallel in that the electron microscope has permitted magnifications never before dreamed and still another hitherto invisible world has come into view.

In the field of chemistry discoveries have been frequent and often of great importance such as radium, previously mentioned, salvarsan and the sulfonamides. With the discovery of the antibiotics the physician's ability to combat disease has been increased immeasurably. One of the most spectacular results of antibiotic therapy is in the treatment of the hitherto uniformly fatal streptococcus viridans endocarditis. This once hopeless condition can now be cured with penicillin in more than eighty per cent of the cases.

The work of William Beaumont (1785-1853) proved that gastric digestion was a

chemical process.⁵³ Biochemistry then became an area of investigation which was in swaddling clothes at the time of our organization. Our first hundred years have been marked by astounding developments in this field and in the related one of nutrition. The riddle of scurvy, beriberi, pellagra and other deficiency diseases has been solved by the discovery of vitamins. Further study of these metabolic regulatory compounds and the thirty odd nutrient dietetic principles will no doubt mean undreamed of progress.

In physiology the chemical approach has been applied with marked success, as exemplified by dozens of important tests. Knowledge of the corpuscular elements of the blood as well as of its serum has progressed to an amazing degree since the early efforts in 1852 of Vierordt in making blood counts. Within the memory even of the youngest of us there have been spectacular advances in the haematological field and an important new specialty has emerged.

In 1846, the word psychiatry was first used and since then the treatment of the mentally ill has been revolutionized. In 1851 mental patients were hidden away and no effort made at treatment. A hundred years later, the mentally ill are no longer regarded as incurable to be incarcerated in asylums. As a result of better diagnosis and new techniques mental patients are treated with an ever increasing effectiveness, with cure possible in many instances. The psychosomatic approach to every illness is receiving ever greater attention. Ultimately mental as well as physical checks will become routine.

In the two decades before the foundation of our Society, the public health movement began to attract much attention in England. The idea lagged in the United States until 1848 when the Medical Department of the National Institute sought the aid of the American Medical Association and recommended:

1st. *The establishment of a permanent committee on hygiene.*

2d. *A recommendation to the various State Legislatures to establish throughout the Union uniform systems for the registration of births, deaths, and marriages.*⁵⁴

51. *Transactions*. . . Louisville: John P. Morton, 1896. New Series, V:297.

52. Emmet F. Horine: The Value of Routine Estimations of Blood Pressure. *Kentucky Medical J.* (Bowling Green), 1X:859, November 15, 1911.

53. William Beaumont: *Experiments and Observations on the Gastric Juice and the Physiology of Digestion*. Plattsburgh, [N. Y.]: F. P. Allen, 1833.

54. *The Transactions of the American Medical Assn.* Philadelphia: T. K. and P. G. Collins, 1848, p. 310.

The resulting reports on hygiene before the American Medical Association clearly disclosed the urgent need of public health measures. Louisiana established a State Board of Health in 1855 followed by Massachusetts in 1869. Kentucky was the tenth to set up such a board (March 16, 1878.)⁵⁵ Dr. Joseph Nathaniel McCormack (1847-1922) was appointed a member of the first Board by Dr. Luke P. Blackburn (1816-1887), then Governor. In 1883, Dr. McCormack was elected its Secretary, a position he held until 1913. At this time his son, Arthur T. McCormack, succeeded him and held office until his death in 1943. The McCormacks, father and son, were connected with the Kentucky State Board of Health for a period of sixty-five years.

Our first President, Dr. William L. Sutton, was one of the national leaders in advocating vital statistics registration acts. He was finally successful in securing such an act for Kentucky (1852.) He presented seven annual reports on vital statistics to the General Assembly. Dr. Sutton may rightly be called the father of vital statistics in Kentucky. As Chairman of the Committee he presented a *Report on a Uniform Plan for Registration Reports of Births, Marriages and Deaths* before the Louisville meeting of the American Medical Association in 1859.⁵⁶

The 1935 convention of the Association was designated by the Program Committee as "The William Loftus Sutton Memorial Meeting." A biographical sketch together with a portrait of Dr. Sutton was made a feature of the printed program. The plan inaugurated by the Program Committee to honor past presidents was adopted by the Council. Elsewhere in this volume (page XLII) will be found a list of those so honored from 1935 to the present.

The Kentucky State Medical Association has continuously recognized the need for improvement in medical education. In 1851 in Kentucky, as in practically all of the other states, one could begin treating the sick without ever having been inside a medical school. The mere announcement that one was a "doctor" was enough to bring patients. A degree could be obtained from any one of the numerous

medical schools after attendance at two sessions of from four to five months each. The lectures of the first session were repeated during the second, including—it is said—even the jokes!

When our Association was organized there were three medical schools in the Commonwealth: one in Lexington, the Medical Department of the Transylvania University; and two in Louisville, the Medical Department of the University of Louisville and the Kentucky School of Medicine. The last-named school was in 1851 closely affiliated with the first one mentioned, as shown by the fact that Benjamin W. Dudley was Emeritus Professor of Anatomy in it and also in Transylvania. Further the following Transylvania professors held active chairs in the Kentucky School of Medicine: Drs. Robert Peter, Samuel Annan, James M. Bush and Ethelbert L. Dudley. This arrangement was made possible by the fact that the lectures in Louisville began in November and continued until March while those in Lexington began on 15 March and lasted four months. Kentuckians may well be proud of the fact that, at that time, the best two medical libraries in the United States were at Lexington (6,660 volumes) and in Louisville (3,216 volumes.)

The Medical Department of Transylvania University finally closed its doors in 1859 and the Kentucky School of Medicine was held to be its lineal descendant. The two Louisville schools carried on, except for disruption during the Civil War, until 1866. A merger was then consummated which lasted only one brief session. Medical jealousies were at that time open and acrimonious, especially between the faculties of the colleges. To make matters worse, more schools were springing up. The Louisville Medical College was established in 1869 and the Hospital College of Medicine in 1874. The Kentucky School of Medicine and the Louisville Medical College were so closely affiliated that their faculties were identical. When Transylvania closed, the Kentucky School of Medicine became a so-called "summer" school, with sessions beginning in March and ending about the first of August. Its affiliate, the Louisville Medical College, held its sessions from November to March. Thus in the eighteen-seventies, a student could enter a "winter" school in November for the first course of lectures, take his second in a "summer" institution and receive a degree in less than ten months!

55. *Acts of the General Assembly of the Commonwealth of Kentucky. . . beginning first day of December 1877.* Frankfort, Ky.: S. I. M. Major, 1878, Vol. I:59-61.

56. *Acts of the General Assembly of the Commonwealth* Philadelphia: Collins, 1859, Vol. XII:135-182.

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In 1882, still another school was established in Louisville—the Jefferson School of Medicine—but it suspended work after graduating one class.

The situation at the time was but little different in other parts of the country. Even in Boston, when President Eliot initiated the reform movement in medical education, he stated that Harvard "had no examination for admission and no standard of preliminary education. Any body could walk into it from the street and many did walk in who could barely read and write."⁵⁷ President Eliot's sincere efforts at Harvard mark the first successful steps in the improvement of medical education. In 1903 Johns Hopkins University under Daniel Coit Gilman (1831-1908) established a really modern School of Medicine with rigid entrance requirements and emphasis on research.⁵⁸ Despite President Eliot's efforts and the example set by Johns Hopkins, medical schools continued to multiply in Louisville as elsewhere. The Southwestern Homeopathic Medical College and Hospital was founded in 1892, while Kentucky University Medical Department was organized in 1894.

Although the evils arising from the existence of too many medical schools had been brought to the attention of our Association and to that of the American Medical Association, nothing constructive was done until 1902. It was then that the American Medical Association through a committee, later the *Council on Medical Education*, initiated a reform movement which proved widely effective. Soon medical colleges all over the country, aroused to action, began to raise their standards by consolidation and by modernization of both plants and curricula. Through mergers the five regular medical schools in Louisville became the School of Medicine of the University of Louisville in 1909. By its own efforts it received a "Class A" rating which it has maintained up to the present. Thus the century which saw the extension of so intolerable a situation in medical education witnessed also its correction to the point where the United States can now boast of the best medical schools in the world.

57. Charles W. Eliot: Discussion [of Report of the Committee on Preliminary Education]. *The A.M.A. Bulletin* (Chicago) Vol. III:262, May 15, 1908.

58. Abraham Flexner: *Daniel Coit Gilman, Creator of the American Type of University*. New York: Harcourt, Brace & Co., [1946], pp. 110-154.

As against the efforts and vicissitudes of our predecessors we may well measure our own fidelity to the profession of medicine. Few of us devote the same time and energy as did they. Rapid communication and easy transportation enable us to treat a far greater number of patients than did physicians of even the preceding generation. A century ago and for many decades thereafter couriers came for physicians and calls were answered on foot, on horseback, in open carts or, occasionally when roads were good, in carriages. I have heard elderly physicians relate stories of professional calls made on horseback, during the winter when, to keep warm, they would dismount and walk miles to reach their patients. There were also those who forced their horses to swim across swollen streams.

With increased leisure there have come also additional distractions and amusements of many sorts, many of them perhaps worthy in themselves, but often incompatible with the long hours of intensive study required of one who would keep fully informed. Advances in medicine are so rapid and numerous that unless a considerable portion of our time be devoted to study we shall inevitably find ourselves practicing antiquated medicine. Samuel Johnson once said that "all intellectual improvement arises from leisure," but we might add *only when used wisely*. When we review the devotion to science of such men as Ephraim McDowell, Benjamin W. Dudley, Charles Caldwell and Daniel Drake—to name but a few of Kentucky's early leaders in medicine—we are humbled by our own inadequacy.

Despite the progress during the past century there remain many and pressing problems which await solution. Cancer must some day yield to research. When we possess a fuller knowledge of the factors involved in arteriosclerosis and other processes of ageing, the span of life will no doubt be further lengthened. The most important unsolved medical problem in the United States today, that of hypertension, remains a riddle and hence a challenge to every physician.

Standing on the threshold of another century, we should be mindful of the necessity of maintaining the confidence of the public. In the past, unfortunately, we have failed to realize the value of taking the layman into our confidence.

We have assumed that our deeds would speak for themselves without the necessity of what is sometimes held to be mere self-seeking "publicity." However, we must recognize the fact that the public has a right to be kept fully informed of our ideals, of our problems, of our programs and of our achievements. Only by spreading such information will it be possible for the public to find a reasoned, dispassionate and adequate—in short, a scientific—answer to the problem with which we are greatly concerned at this time, of how best to afford effective and complete medical care for all. In a truly democratic nation, the theory that governmental controls can provide adequate medical care seems wholly invalid.

In order to find answers to our present problems which shall be in accord with the best traditions of our country and of our profession we need to make certain that the public is fully informed. It is therefore wise that our Council should have employed a person who will devote his entire time to public relations. A further step will no doubt be the selection of a group of interested laymen to serve in an advisory capacity and to help interpret for us the viewpoint of the public.

The Kentucky State Medical Association has adopted the following goals as it begins a new century:

ETHICS

1. To constantly improve the high standard of ethics of our profession and inspire by example and precept among medical students and young practitioners a sanctity of the trusts committed to us.

CITIZENSHIP

2. To encourage the members of our profession to participate in local activities of civic improvement and building good American citizenship.

LEADERSHIP

3. To assume an alert leadership in all matters pertaining to health to the end that we may provide for all Kentuckians the best medical care which the State's resources will afford.

COOPERATION

4. To secure the cooperation of all professions and agencies in a constructive and progressive program of health throughout the State.

PREPAID CARE

5. To promote prepaid hospital and sickness insurance to individuals as

well as groups through our own and reputable private agencies.

THE PUBLIC

6. To inform the public of the problems of medical service and how they may secure the best medical care, and to solicit their confidence and cooperation in efforts devoted to their best interest.

INDIGENTS

7. To provide more equitable and adequate medical care for indigent citizens in every community.

PUBLIC HEALTH

8. To actively cooperate with the State Department of Health and with local health departments in initiating and carrying out a sound public health program designed to control preventable disease and to safeguard the health of the people.

INSTITUTIONS

9. To constantly promote the improvement of curative medical care in our State Tuberculosis and Mental Hospitals and to coordinate and support programs that combat heart disease, cancer, diabetes, poliomyelitis, and other similar devastating diseases.

HOSPITALS

10. To expand and improve present hospital facilities to the end that all citizens may have available within their reach the benefits of the best scientific diagnosis and treatment of disease.

EDUCATION

11. To educate an adequate number of physicians, nurses, and technicians and seek their more equitable distribution to all communities; to foster medical research and extend to all the benefits of postgraduate study.

LEGISLATION

12. To maintain close liaison with the Federal, State and County governments to the end that the best health interests of our citizens will be served.

The purpose of this sketch has been to note briefly the progress of the Kentucky State Medical Association in relationship to the medical advances of the past century. The situations which challenge us as we enter upon a new century are manifold. Let us emulate the faith and energy of our predecessors and resolve that we shall serve our fellowmen not less steadfastly than they.

AUGUST

8-14 — 11th Annual Scientific Meeting and Exhibition of the Society of Magnetic Resonance in Medicine; Berlin, Germany. Contact: SMRM, 1918 University Avenue, Suite 3C, Berkeley, CA 94704; 510/841-1899; FAX 510/841-2340.

SEPTEMBER

3-5 — Perinatal Medicine; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

25-26 — 5th Annual Rehabilitation Management for the Primary Care Physician; Radisson Plaza Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

25-26 — 6th Annual Multispecialty Oculoplastic Surgery Symposium — A conjoint symposium by specialties involved with the management of problems of the midface and ocular adnexa; Marriott's Griffin Gate Resort, Lexington, KY. Contact: Julie Burlew, RN, The Center for Advanced Eye Surgery, Humana Hospital-Lexington; 606/268-3769.

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The Truth About Mammography

The news media has been ablaze with sizzling, highly dramatized but, in most cases, probably accurate reports of poor quality mammography centers.

If Diane Sawyer were to visit your office today, what could you tell her about mammography? Are you protecting your female patients? Sawyer's check list for patients regarding the facility performing the mammogram and the physician was excellent. But are you, as a referring physician, familiar with the pitfalls and myths about mammography and needle localizations?

The following list of pitfalls should be familiar to all referring physicians:

Pitfalls of Mammography and Needle Localizations

1. *Assuming a palpable lesion is not significant because the mammogram is normal.* Only 85% of breast carcinomas are detectable by mammography.

2. *Refusal or reluctance of a patient to get a mammogram, due to the discomfort of the procedure, may delay diagnosis.* Explanation of the need for good compression of the breast tissue and the necessity of some discomfort, but rarely pain, should increase patient compliance.

3. *Very dense breasts, commonly seen in younger patients, may obscure lesions.* Some comment about breast density should be made by the radiologist and should guide the clinician as to the reliability of the mammogram.

4. *Substandard equipment or*

"Mammography remains the best technique for identifying early breast carcinoma."

positioning may give a false sense of security by producing suboptimal examination (using American College of Radiology accredited facilities may protect the patient in this instance).

5. *Assuming a needle localization and breast biopsy is 100% effective in eradicating the possibility of cancer in a patient with a suspicious mammogram.* There is a 4% failure to excise lesions nationally. The patient needs to know this prior to a needle localization and biopsy, and some authorities recommend limited follow-up mammograms in 3 to 6 months of the breast that was biopsied to detect any nonexcised lesions.

6. *Assuming a transected wire, an infrequent but potential complication of needle localizations, is no cause for concern.* Transected wires may migrate and have been reported in distant sites including the axilla, the back, the politeal space and the myocardium. Usually, the wire incites a fibrotic response which limits migration. The patient may elect to have the wire removed or a follow-up film in 6 months. Conclusive evidence is not available, however, if migration has not occurred in 6 months the likelihood of migration is small.

7. *Assuming you can always tell benign calcifications from malignant ones on the mammogram.* With macro-calcifications or large calcifications, this is true. However, there is increasing evidence that new

or changing micro-calcifications, regardless of their shape, size, or number, must be considered suspicious for a malignancy and biopsy is recommended.

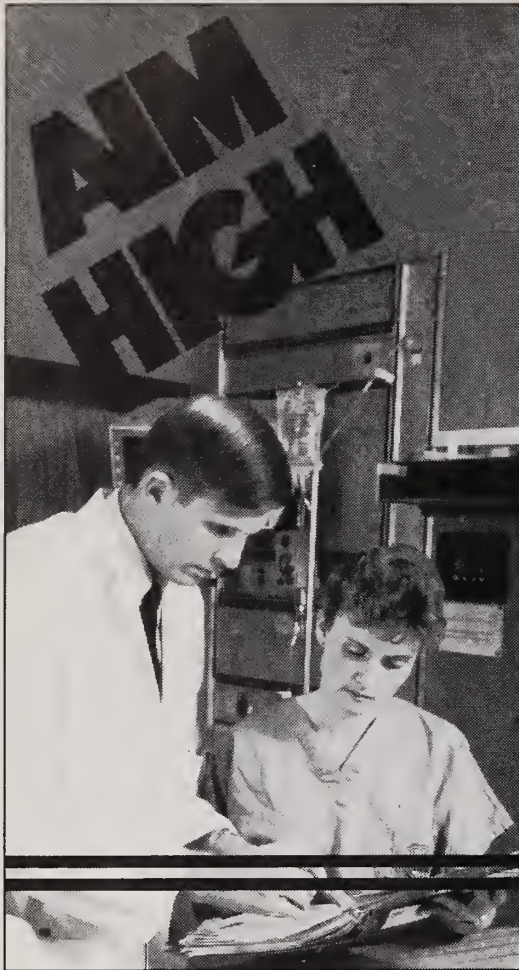
8. *Assuming risk factors are helpful in mammographic interpretation.* According to Baker in his 5-year Breast Cancer Demonstration Project, (California, 1982), 80% of women who have breast cancer have none of the traditional risk factors.

9. *Assuming an unchanging mammographic lesion after 1 year proves the lesion is benign.* While an unchanging abnormality over a 1-year period suggests a benign lesion, breast cancer may be stable over 1 year, especially in the elderly patient. The recommended follow-up protocol is initial follow-up exam 3-6 months, then every 6 months for 2 1/2 years, then annually.

10. *Assuming all breast cancers have malignant features on the mammogram.* Unfortunately, 20% of malignant lesions have benign features on the radiograph. Therefore, it has become customary to biopsy or follow radiographically all solid lesions greater than 8mm in diameter in spite of their appearance. The universal experience with needle localization of nonpalpable lesions is that for every 10 lesions biopsied, 2 to 3 will be malignant.

Mammography remains the best technique for identifying early breast carcinoma. By being aware of these pitfalls you can help maximize this valuable diagnostic tool.

Jannice O. Aaron, MD



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The AMA Auxiliary

The American Medical Association Auxiliary will hold its annual convention June 21-24, 1992, at the Drake Hotel in Chicago. The Auxiliary to the Kentucky Medical Association will be represented at this meeting by the following delegates:

Cheryl Houston
Marla Vieillard
Gloria Griffin
Beryl Dodds
Pam Blackstone

Attending as alternate delegates will be:

Jo-Ann Daus
Angela Watson
Angela DeWeese

Esther Jansing (AKMA President 1989-90) will also be attending as a member of the 1991-1992 AMAA Health Promotion Committee. Esther has been asked by incoming AMAA President Priscilla Gerber to chair this committee for 1992-1993 and to serve as a member of the AMA Auxiliary Board of Directors.

The goal of the AMA Auxiliary is to serve its membership and through a strong federation of county, state, and national auxiliaries, to work with medical societies and other organizations to address the health needs of the public and the concerns of the medical profession. The Auxiliary pursues this objective by helping state and county auxiliaries identify community needs and by providing information on how these needs may be addressed through educational programs and action projects. The AMA Auxiliary functions primarily as a catalyst rather than as a participant in community projects, providing information and training to the state and county auxiliaries.

Information is provided through the Health Promotion Committee, the Health Promotion Handbook, and the Project Bank. The Project Bank is an information clearinghouse for programs and projects developed by medical auxiliaries. Currently, the bank holds complete descriptions and resource materials for more than 1,000 projects, each of which is listed in an annual catalog and sent to state and county auxiliaries.

The AMA Auxiliary policy on health issues is set by the House of Delegates, in consultation with and with the approval of the AMA. Resolutions passed by the House of Delegates since 1980 have focused on adolescent health, AIDS education, seatbelt safety, cancer prevention, child abuse, substance abuse, teen suicide prevention, family violence, and other health issues.

Another objective of the AMAA is to work with the medical profession to address mutual concerns. Our approach to this objective is to support AMA programs, as well as those of state and county medical societies and associations. These programs include fund raising for AMA-ERF, legislative activities, and various special programs.

The AMA Auxiliary also offers leadership training sessions, through which the national auxiliary transmits its expertise to all auxiliary members. The AMA Auxiliary Leadership Confluence is the organization's major source of leadership training. Held since 1975 to offer indepth seminars on leadership and health issues, it is designed as a training ground for county presidents-elect. Confluences have been held twice a year since



"In order for us to continue to reap the benefits of a strong national organization, we must keep our membership up. If your county has an organized medical auxiliary, I encourage you to join all three levels of the federation."

1986 and are also attended by state presidents and presidents-elect (nominated presidents-elect attend Confluence II) and national board and committee members. The quota of county presidents-elect who are reimbursed 75% of their travel expenses is determined on the basis of a state's AMA Auxiliary

"What happens to medicine happens to you. Whatever your involvement outside the Auxiliary, you represent medicine, since medicine is an integral part of your life and your lifestyle."

membership; other county presidents-elect can attend on a space-available basis.

Confluence sessions emphasize leadership training, as well as information that can be put to use in local communities. In 1991-1992 seminars focused on domestic violence, environmental concerns, older Americans, working with the broadcast media, speaking and

listening skills, and parliamentary procedure. An optional constituent skills workshop sponsored by AMPAC was held prior to the meeting in 1990-91 and 1991-92.

Leadership Confluences also include separate plenary sessions for county presidents-elect, and state presidents, presidents-elect, and nominated presidents-elect. These sessions focus on leadership development, working with medical societies, and programming. Recently, the time frame was expanded to offer a session with a professional facilitator on team building, problem solving, and other leadership concerns. A further expansion made time for a special membership presentation.

State auxiliaries can request that members of the AMA Auxiliary board and committees attend their annual state meetings, board meetings, workshops, and county meetings to provide keynote addresses, program information, and other services. From 1985 to the present, emphasis has been on the importance of national personnel visiting county auxiliaries, and national representatives are encouraged to seek opportunities for interaction with members on all state and county visits.

In order for us to continue to reap the benefits of a strong national organization, we must keep our membership up. If your county has an organized medical auxiliary, I

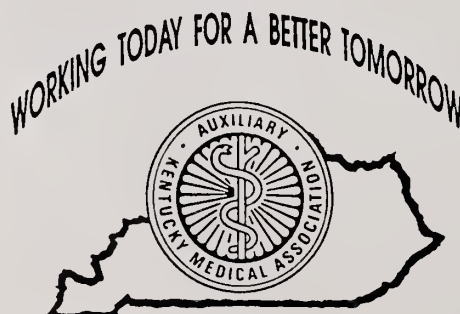
encourage you to join all three levels of the federation. What happens to medicine happens to you. Whatever your involvement outside the Auxiliary, you represent medicine, since medicine is an integral part of your life and your lifestyle. By joining all three levels of the federation, you make it possible for the national auxiliary to continue to provide the leadership training and programming that helps us make a difference in the health care of Americans. Join us as we work today for a better tomorrow by being a federated member of the auxiliary.

If you live in an area that does not have an organized auxiliary, I encourage you to become a member-at-large. You will receive valuable information to help you stay knowledgeable about health care issues. For information on AKMA membership contact:

Jean Wayne, Executive Secretary
AKMA Office
Hurstbourne Forum Office Park I
301 N Hurstbourne Pky, Suite 200
Louisville, KY 40222-8512
502/426-6200

Please join us as we work today for a better tomorrow.

Beryl Dadds
AKMA President



RATES AND DATA

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Deadline: First day of month prior to month of publication.

Word count: Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

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FOR SALE — 65cm flexible sigmoidoscope, 300 watt light source, Gomco suction pump, 3 tier procedure cart, and power exam table. Used fewer than ten times, cost \$12,000 new, sell for \$6,000. Call day 502/895-3401 ext 5693, evening 502/769-6406.

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TOP: Royce E. Dawson, MD, Owensboro, President, Kentucky Board of Medical Licensure. **CENTER:** AKMA President Pam Blackstone, Owensboro. **BELOW:** Alfred L. Thompson, Jr, MD, Vice Dean for Clinical Affairs, U of L School of Medicine.



Board of Trustees Spring Meeting

The KMA Board of Trustees held its two-day Spring meeting on April 15 and 16, 1992, at the Radisson Hotel in Louisville. The Board members heard reports from the President, the Secretary-Treasurer, the Auxiliary President, the Senior Delegate to AMA, the Vice Dean of the University of Louisville School of Medicine, the Chairman of the KMIC Board of Directors, and the President of the Board of Medical Licensure.

The Board adopted a budget for the 1992-93 Association year, appointed three Board members to serve on a KMA/KMIC Liaison Committee, and approved implementation of a formalized Impaired Physicians Program with a full-time medical director. Nominees were selected for the KMIC Board of Directors, and reports of the Membership Committee and the Cancer Committee were also accepted.

The Board authorized the KMA Vice President to work with an infectious diseases consultant to produce an "OSHA Exposure Control Plan" to meet requirements of the Occupational Safety and Health Administration's Final Standard on Blood-borne Pathogens. The Board directed that the plan be made available to members at cost.

Comprehensive reports were given concerning the activities of the Committees on National and State Legislative Activities, which included details of the 1992 Kentucky General Assembly. The Chairman of the Committee on State Legislative Activities reviewed several subjects which have generated considerable controversy during the past several

General Assemblies, including issues involving nurse practitioners, Certificate of Need for physicians' offices, and mandatory continuing medical education.

The Board spent considerable time discussing a KMA plan for health care reform to submit through the Task Force and Health Care Commission to the General Assembly. In doing so, the Board members reviewed various policies and positions of the Association which relate to the legislative process. An extensive KMA plan was adopted utilizing KMA House of Delegates policies which the Board members felt address issues which should be considered in any serious attempt at health care reform.

Recognizing that KMA would be required to deal with all phases of health delivery during the deliberations, the Board of Trustees authorized the KMA Quick Action Committee to represent the Association in all matters relating to the Special Task Force, Commission, and Special Session. The Board also authorized the President to call emergency meetings of the Board and special sessions of the House if indicated. Realizing the need for professional assistance, the Board authorized KMA to contract with a public relations firm to assist the Association in devising various public, legislative, and membership strategies to prepare for the Special Session of the General Assembly planned for November 1992.

The next regular meeting of the Board was scheduled for August 5-6, 1992.

KMA



LEFT PHOTO: President-Elect William B. Monnig, MD, Edgewood (L), and Immediate Past President, Preston P. Nunnelley, MD, Lexington. **RIGHT PHOTO:** Lillie R. Byrd, KMA Director, Financial Operations, will be retiring at the end of June 1992. She is pictured with KMA Past President Richard F. Hench, MD, Lexington. Dr Hench currently serves as Chairman of the KMIC Board of Directors.



ABOVE: AKMA President Pam Blackstone presented AMA-ERF checks to the state's two medical schools. H. David Wilson, MD, Associate Dean for Academic Affairs, accepted the contribution for the UK College of Medicine. **BELOW:** AMA Senior Delegate and KMA Past President Donald C. Barton, MD, Corbin.

L to R: KMA Executive Vice President Robert G. Cox, Board Chairman Russell L. Travis, MD, Lexington, and President S. Randolph Scheen, MD, Louisville.



Wally O. Montgomery, MD, Paducah, Chairman of the Committee on State Legislative Activities and KMA Past President.



William P. VonderHaar, MD, Louisville, KMA Secretary-Treasurer, presented a report to the Board.





Lillie R. Byrd

'Take Me Out to the Ball Game!'

Strange title for an article on a retiring Kentucky Medical Association employee? Not really. Not if you know the employee.

With KMA as her playing field for more than 26 years, Lillie Byrd will watch the lights go out on the scoreboard for the final time on June 30, 1992, and will enter the dugout of retirement. The final score will show *two* winners — Lillie Byrd and the Kentucky Medical Association. Through the years as the game was played, they complimented each other — both professional, of the highest integrity, dedicated, and always striving to win for their team, the physicians of Kentucky.

Why the baseball theme?

Because during many of these years, Lillie and her husband Larry devoted most of their "leisure" time to their family, baseball, their son Paul and baseball. Their dedication and devotion to the all-American game is now being rewarded on the professional "Field of Dreams." After helping many youth advance into Little League World Series and College World Series, they now have an opportunity to help their favorite

player into THE World Series. Their son Paul was drafted in 1991 as a pitcher for the Cleveland Indians, and Lillie is more than excited about traveling around the country encouraging her #1 player on the mound. KMA has been the beneficiary of her skillful handling of financial affairs for many years, but Summer is here, the outdoors is inviting, baseball is in full swing, and her son is pitching. Ending the KMA game and retiring suddenly seems the winning thing to do!

Lillie began her career with KMA on April 25, 1966, as a bookkeeper. J. P. Sanford was KMA Executive Secretary and a few of her fellow employees were Robert G. Cox, Gilbert A. Armstrong, Ann Huntsman, Violet Stilz, and part-timer Fay Miles, who was to become her closest personal friend. This was the same year that the Kentucky General Assembly adopted legislation mandating PKU testing of newborns; the KMA staff implemented a new project to add ZIP codes to our mailing lists; and Medical School tuition at the University of Louisville was raised to \$1200 a year.

"While the entire staff will miss Mrs Byrd's presence in the office, I suppose her absence will be more obvious to me than anyone, since I am the only present staff member who was here when she was hired over 26 years ago."

— R.G. Cox
KMA Executive Vice President

Reminiscing, it seems that Lillie is surely the employee with the longest service to retire from the KMA staff, but Lillie decided a long time ago that she would never hold that distinction. The reason? Violet Stilz completed 43 years with KMA before her retirement in 1966. Lillie has too much travel and too many ball games ahead to reach for that goal!

Through the years, dedication, hard work, and a superb business acumen led Lillie to become the Association's first female executive as Director, Financial Operations. During her tenure, she has seen the Association's assets grow from less than one million to more than six million dollars.

Executive Vice President Robert G. Cox recognizes the void created when a valued employee retires. "While the entire staff will miss Mrs Byrd's presence in the office, I suppose her absence will be more

"Thank you for a long and valued career of service to the physicians of this state. You have earned a well deserved rest."

— Russell L. Travis, MD
KMA Board Chairman

obvious to me than anyone, since I am the only present staff member who was here when she was hired over 26 years ago. That many years of dedication to and effort for the Association is significant, and she has had a role in many of the changes and growth that have taken place in KMA during that time."

Though he will miss her, as always he expressed pleasure in seeing one of his employees achieve a milestone in life. "We know that Lillie has traveling on her mind and a lot of other plans for a busy retirement. We extend our best to her and to her husband, Larry, for many years of good health, fun, and well deserved relaxation."

The KMA Board of Trustees paid tribute to Lillie's many years of unselfish dedication and service to the Association with recognition at the April 16 meeting. As the Board gave her a standing ovation, Chairman Russell Travis, MD, closed with these remarks. "Lillie, we recognize your long tenure at KMA and your contributions toward our success. On behalf of the Board of Trustees and the members of KMA, we offer our very best as you retire. Thank you for a long and valued career of service to the physicians of this state. You have earned a well deserved rest."

In turn, Lillie recognizes the rewards she has reaped from her

association with KMA, as evidenced by her comments. "Retiring from KMA after 26 years of service in the Financial Department will leave me with many cherished memories. Over the years, I was proud to see KMA develop into the progressive organization it is today. Most of all, I am grateful for the many friendships afforded me both inside and outside the medical profession. I extend my best wishes for continued success to all my co-workers and the many doctors and dedicated board members who make up such a great organization as KMA."

Lillie has been married for almost 30 years to Larry Byrd, who retired last October following a career in law enforcement. In addition to their son Paul, they have three other children and five grandchildren. Daughter Carletta is self-employed and lives in Louisville with her three children. Eldest son Mike lives in Mount Washington and is employed with Ford Motor Company. Another son, Rick, operates the KMA print shop and has been a valued KMA employee for 18 years. He and his wife Lori live in Louisville with their daughter Hilary.

In addition to family activities and baseball, Lillie is active in her church and is always willing to befriend those in need, especially the elderly and the young . . . and her co-workers, who will miss her greatly.

And so as the game ends, please allow us to speak for the Association and her fellow employees by wrapping up our post-game comments with this message:

"Lillie, we know that you will play the game of retirement with the same enthusiasm and dedication that you displayed during your many years of KMA employment — and you will win the game. One thing's for sure, your co-workers through the years would all agree that KMA hit a home run when it hired you — and together you won that game."

KMA



Lillie looked on humbly as the KMA Board gave her a standing ovation.

PEOPLE

William G. Danneman, MD, of Crestview Hills, recently received a 3-year appointment as Cancer Liaison Physician for the Hospital Cancer Program at St. Elizabeth Medical Center. The Cancer Liaison Program is an integral part of the Commission on Cancer of the American College of Surgeons.

Prasaad Steiner, MD, U of L Department of Family Practice, has been certified by the American Board of Preventive Medicine as a Specialist in Public Health and General Preventive Medicine.

UPDATES
**Forensic Medicine Training for
Emergency Doctors**

A team of University of Louisville doctors has created the first clinical forensic medicine training program in the United States. **William S. Smock, MD**, is a resident in emergency medicine and assistant state medical examiner. He has worked with Peter Fuller, professor of anatomical science and neurobiology, and **George R. Nichols, II, MD**, clinical associate professor of pathology and state medical examiner, to establish and promote the new program.

The program was designed to meet the needs of patients who are survivors of violent injury and trauma and those patients who have not yet died from their injuries. It incorporates clinical forensic training into the emergency medicine residency program and provides for a 1-year fellowship.

According to Dr Smock, physicians in the program will learn medicine from the legal aspect to

accurately assess and preserve the physical evidence in gun and stab wounds, physical and sexual assault, and motor vehicle-related traumas. Often, in their efforts to save lives, emergency room personnel inadvertently destroy such evidence.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Barren

George S. Allen, III, MD — OBG
1411 N Race St, Glasgow 42141
1984, U of Kentucky

Boyd

Mario E. Eyzaguirre, MD — PD
2620 Central Pky, Ashland 41102
1979, Cayetano Heredia U

Bell

Maria A.V. Hortillosa, MD — AN
3513 Cumberland Ave, Middlesboro 40965
1970, U of Santo Tomas

Clay

Javier A. Vasquez, MD — S
401 Memorial Dr, Manchester 40962
1972, Cayetano Heredia U

Fayette

James W. Atchison, DO — PMR
2050 Versailles Rd, Lexington 40504
1987, Ohio U of Osteopathic Medicine
James W. Banks, MD — FP
820 S Limestone, Annex 4, Lexington 40536
1984, Marshall U
David M. Blake, MD — N
1221 S Broadway, Lexington 40504
1984, U of Kentucky

Mark E. Einbecker, MD — S
1780 Nicholasville Rd #501, Lexington 40503

1985, Northwestern U
Carol L. Fowler, MD — S
4030 Bates Creek Rd #1002, Lexington 40517

1979, Louisiana State U
Daniel J. Joyce, MD — ORS
100 N Eagle Creek Dr, Lexington 40509

1979, Wayne State U
John J. Lazarchick, MD — PTH
PO Box 680, Lexington 40586

1986, Medical U of South Carolina
Michael E. Sekela, MD — TS
UKMC — MN 276, Lexington 40536

1981, Albert Einstein Col of Medicine
Albert Speech, MD — OTO
1401 Harrodsburg Rd #A-580, Lexington 40504
1982, State U of New York

Fulton

Richard M. Buurman, MD — FP
300 N Highland, Fulton 42041
1986, Medical College of Georgia

Jefferson

Tobias Enright, MD — A
3802 Tynebrae Ct, Louisville 40241
1974, U of Guadalajara

Robert D. Fechtner, MD — OPH
301 E Muhammad Ali, Louisville 40202

1982, U of Michigan
Frank E. Lee, MD — R
6400 Dutchmans Pky #55, Louisville 40205

1986, U of Louisville
Allan Tasman, MD — P
5105 Dunvegan Rd, Louisville 40222
1973, U of Kentucky

Laurel

Joseph W. Stern, MD — OBG
1406 W 5th Street #303, London 40741
1958, Wayne State U

Ohio

Mary E. Quillinan, DO — IM
Box 228, Beaver Dam 42320

1986, Philadelphia Col of Osteo
Medicine

Scott

Huey P. Wyatt, MD — P
525 E Main St, Georgetown 40324
1958, Louisiana State U

New In-Training

Fayette

Marcia L. Cave — OBG
Scott W. Hardigree, MD — AN
Marshall G. Howell, III, MD — OBG
Edward S. Lim, MD — OPH
Walter E. Pofahl, MD — S
John W. West, MD — R

Jefferson

James E. Brown, Jr, MD — EM
Cheryl Gebhardt Cowens, MD — IM
Kimberly Y. Eakle, MD — IM
Larry J. Gross, MD — P
Charles J. Kaiser, MD — OPH
Denise A. Kolbet, MD — IM
John T. Mahan, MD — S
Mark A. McBride, MD — PD
Francis H. Tsung, MD — OBG



Medical Challenges In An Age Of Risk

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DEATHS

Glenn R. Powell, MD
Harrodsburg
1930-1992

Glenn R. Powell, MD, a retired general practitioner, died March 12, 1992. A 1955 graduate of the University of Louisville School of Medicine, Dr Powell was a life member of KMA.

F. Glover Plymale, MD
Louisville
1910-1992

F. Glover Plymale, MD, retired obstetrician-gynecologist, died April 3, 1992. Dr Plymale graduated from the University of Louisville School of Medicine in 1935 and was a life member of KMA.

Cornelia B. Wilbur, MD
Lexington
1903-1992

Cornelia B. Wilbur, MD, a retired psychiatrist, died April 9, 1992. Dr Wilbur graduated from the University of Michigan Medical School in 1939. She was known as an authority on multiple personality disorder, and was featured in the book and movie *Sybil*, the story of a woman with multiple personalities. Dr Wilbur was a life member of KMA.

Leslie W. Langley, Jr, MD
Rineyville
1923-1992

Leslie W. Langley, Jr, MD, a retired pediatrician, died April 11, 1992. A 1953 graduate of the University of Louisville School of Medicine, Dr Langley was a life member of KMA.

John D. Gordinier, MD
Louisville
1912-1992

John D. Gordinier, MD, a retired obstetrician-gynecologist, died April 9, 1992. A 1935 graduate of Tulane University School of Medicine, Dr Gordinier was a life member of KMA.

Robert J. Griffin, MD
Lexington
1904-1992

Robert J. Griffin, MD, a retired OB-GYN, died April 22, 1992. A 1931 graduate of the University of Pennsylvania School of Medicine, he became health officer for Scott County in 1935. He also worked for the state and Fayette County health departments, and was a UK medical school professor and life member of KMA.

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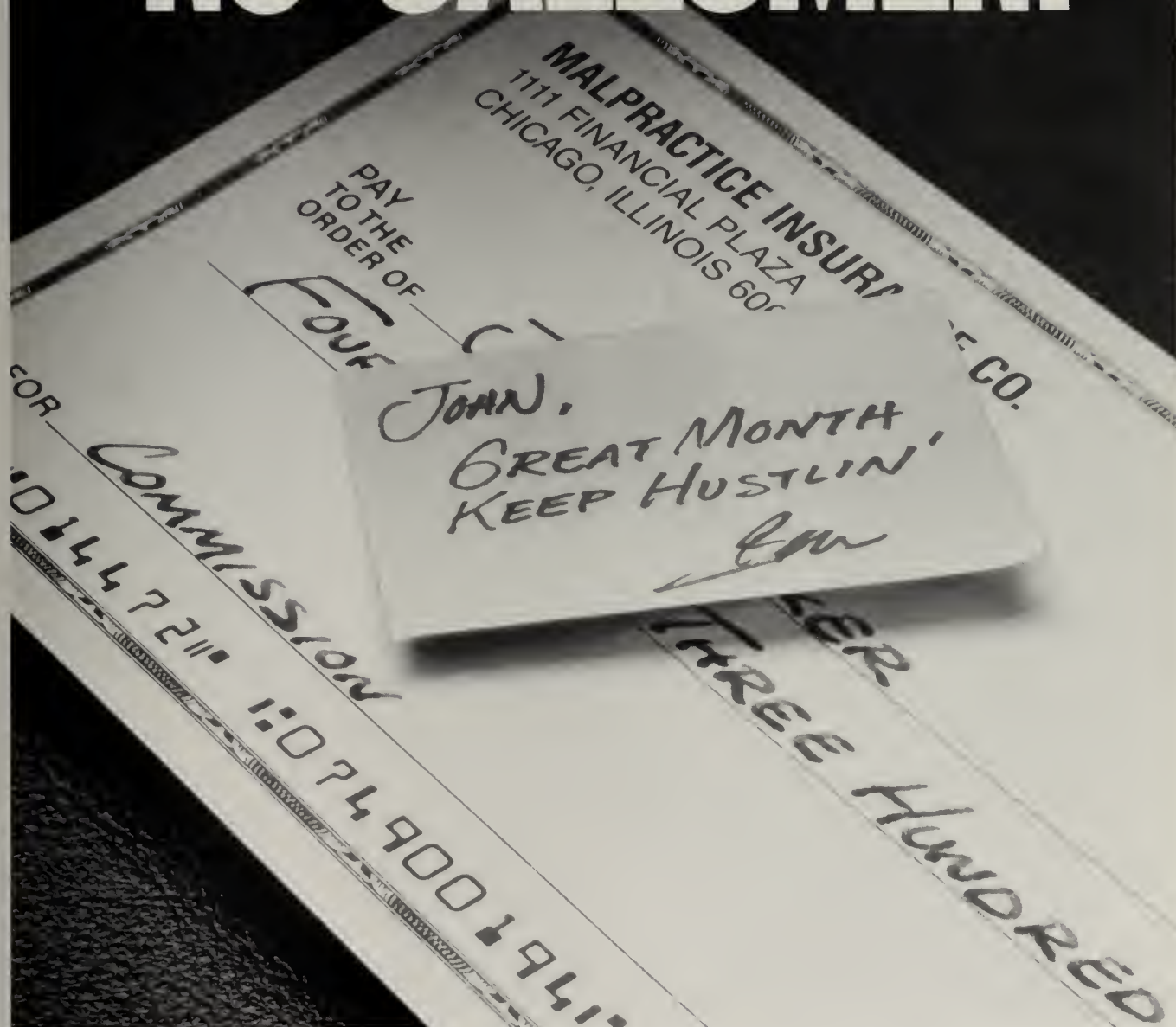
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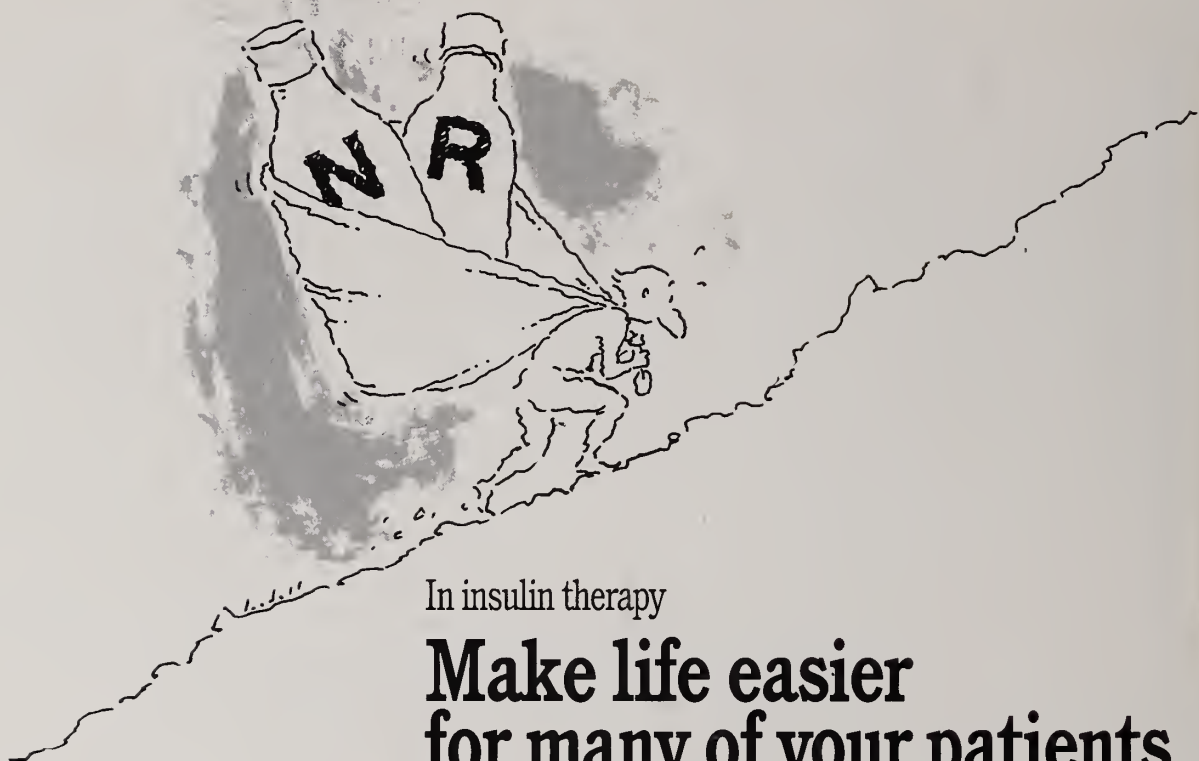
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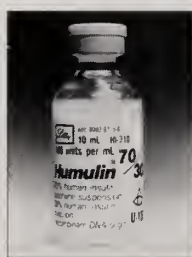
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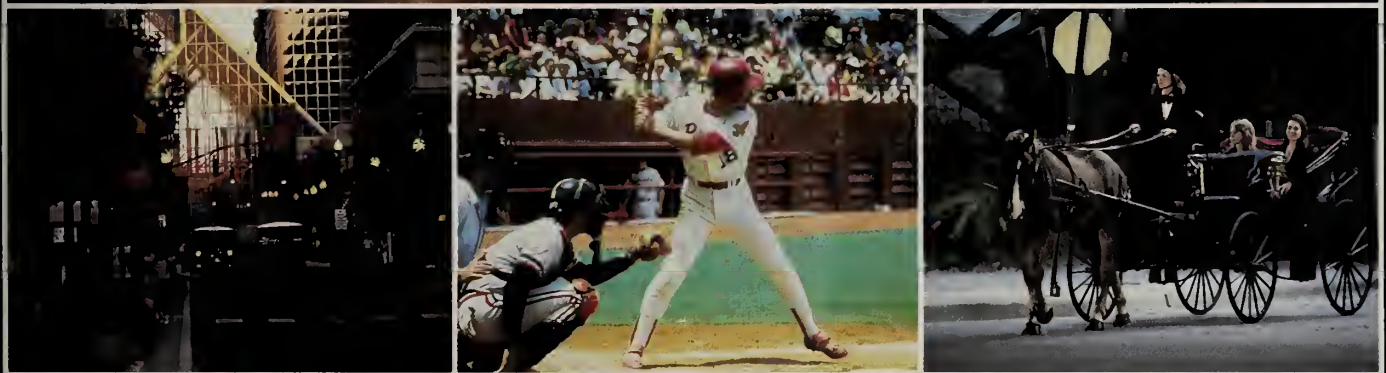
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SEPTEMBER 13-17

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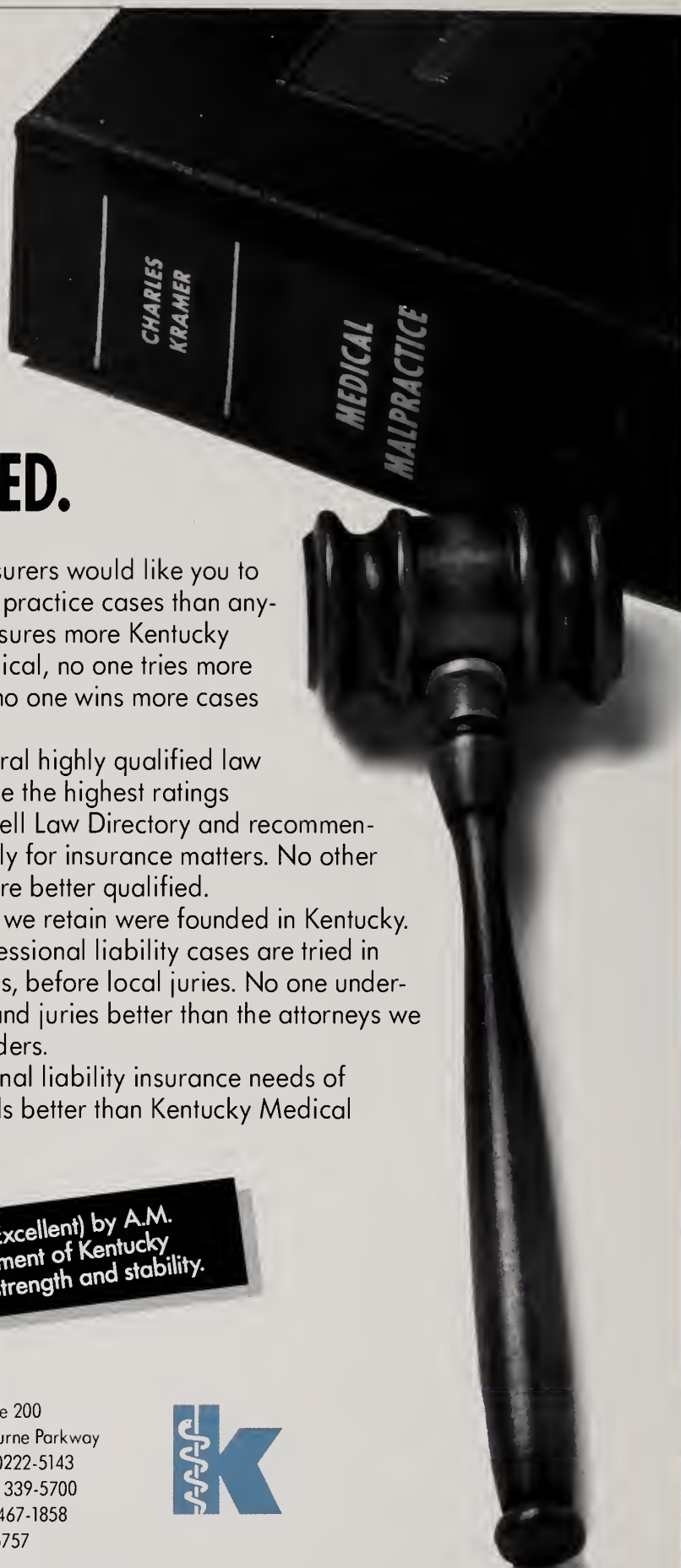
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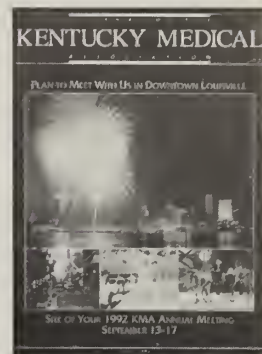


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JULY 1992

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COVER: Downtown Louisville, site of the 1992 KMA Annual Meeting, offers a wealth of things to see and do — a few of which are featured on our cover. Fireworks explode in a nighttime view of the waterfront and downtown Louisville, a view which can be enjoyed while strolling on the Belvedere or more spectacularly while dining in one of the rooftop restaurants. The Gallerio features several levels of specialty shops for your enjoyment, and Louisville Redbirds baseball is but one of Louisville's exciting sports offerings. For a relaxing change of pace, take a leisurely ride through downtown in a horse drawn carriage. Photos courtesy of Louisville Convention & Visitors Bureau.

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Donald C. Barton, MD

Your Kentucky Delegation

"The big issue facing us on both a state and national level this coming year is health care reform. We must all become informed and involved if we hope to retain any resemblance to our free enterprise system."

Your Kentucky Delegation is making plans for the annual meeting to be held in Chicago in June. We expect this to be a very busy meeting since we have all experienced the frustration of the new RBRVS system this year.

In December, we considered 214 resolutions and 90 reports on a wide variety of national issues affecting physicians in the United States. HIV testing for health care workers and the development of a national policy regarding the new Medicare payment system were two difficult issues that received the most attention from the delegates and the national press.

The reports and actions taken on the subjects of HIV and RBRVS payment reform are very lengthy, and I will not repeat them at this time; but they are readily available if any of you desire them. I will assure you that the AMA is well aware of the problems encountered in the system, and we are totally committed to continuous RBRVS refinement and updating.

With over 300 items of business and scores of ancillary caucuses, seminars, and conferences, this was a hardworking meeting that required

much study and preparation for all in attendance.

Kentucky submitted two Resolutions to the AMA House this year. The first asked AMA to develop ethical guidelines for physicians serving in capacities that do not involve direct patient care, but involve the exercise of medical judgement. The Resolution was well received by the House, and Kentucky's Resolution was adopted.

The second Resolution called on the AMA to continue its support of anti-hassle legislation, and for the AMA to work with HCFA and Congress to reduce federal spending and deficits in health care. The Resolution came about in response to the move by HCFA to freeze or reduce physician reimbursements under the Medicare program in the name of cost containment. While much of the actual cost increase in Medicare is not due to physician fees, but technology, increases in the number of people eligible for coverage, and increased administrative costs, efforts to reduce these costs often come at the expense of the physician. Since this Resolution was reaffirmation of existing AMA

policy, the existing AMA policy was reaffirmed.

In addition to your eight delegates and alternates, we are always pleased to have good representation by our Executive Committee. We also have strong representation from our students, residents, hospital medical staff section, and young physicians, and their input into our discussions of the issues is extremely valuable and greatly appreciated.

Dr Ardis Hoven was appointed this year to serve on the Advisory Committee on Group Practice Physicians, and we are all very pleased with this appointment. It goes without saying that Ardis will do her usual excellent job in representing Kentucky on that body.

The AMA is working daily on our behalf in Washington. Some of the issues are student loan deferments; inequities in young physician payments of Medicare; OSHA regulations on medical waste; and lack of payment for interpretation of

"I will assure you that the AMA is well aware of the problems encountered in the system, and we are totally committed to continuous RBRVS refinement and updating."

EKGs; just to name a few. Of course, the big issue facing us on both a state and national level this coming year is health care reform. We must all become informed and involved if we hope to retain any resemblance to our free enterprise system. If you are not a member of KEMPAC and AMPAC, don't put it off any longer. Join today and include your spouse. Two hundred dollars is a very little investment for the return you receive. I would urge all of you to become

AMA members and let's all work together for our profession. I am happy to say that our membership is up, and I thank you.

There are many issues addressed at meetings of the House, but time prevents me from commenting on them all. The meetings of the AMA House are conducted in a most democratic manner. A wealth of information is disseminated and discussed. I would encourage you to attend and participate. Any member of the Association may present testimony at the Reference

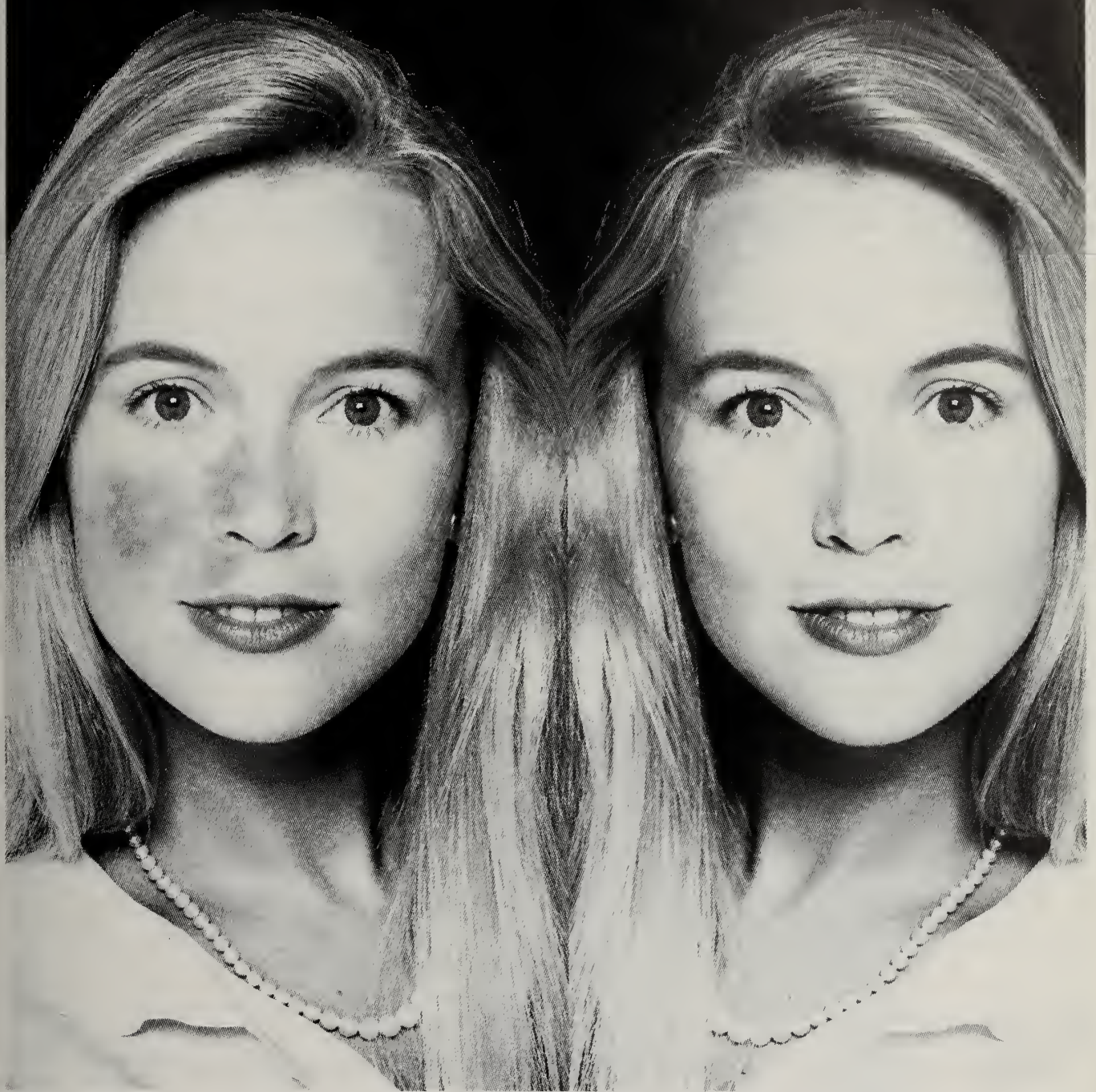
Committee. If you can't come to the meeting, you can still be represented through your delegation. Let us know your opinions. Many AMA policies began with an individual physician who had a good idea and coaxed it through the democratic process.

On behalf of the Delegation, thank you for allowing us to serve you.

Donald C. Barton, MD
AMA Senior Delegate

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Pulmonary Emphysema in a Nonsmoker With Normal Alpha-1-Antitrypsin

Karen R. Habenstein, MD; Thomas M. Roy, MD; Cheryl L. Fields, MD

Premature and rapidly progressing emphysema of the lung is unique in the absence of cigarette smoking or an inherited homozygous alpha-1-antitrypsin deficiency. We describe a young man with radiographic evidence of early onset bullous emphysema without the usual risk factors and provide a review of the alternative explanations proposed for this form of lung damage.

He had recently applied for employment as a material handler for a lumber yard. His pre-employment physical examination included a chest radiograph that showed significant bullous emphysema. The patient was referred to us for evaluation because of the employer's concern about a potential spontaneous pneumothorax

From the Division of Respiratory and Environmental Medicine, University of Louisville School of Medicine, and the Louisville Veterans Administration Medical Center, Louisville, KY.

Introduction

Pulmonary emphysema results from destruction of the connective tissue of the lung with resulting distal airspace enlargement. The elastin and collagen matrix is damaged by a relative excess of unopposed protease. Two explanations for the imbalance of enzymes that allows degeneration of the lung's architecture are commonly accepted. Most frequently, an acquired increase in protease results from the stimulation of neutrophils and macrophages by cigarette smoke to release leukocyte elastase. An inherited deficiency in the antiprotease alpha-1-antitrypsin is the second, but much less common, possibility.

While these two situations serve to explain most cases of emphysema, the National Heart Lung and Blood Institute has initiated an investigation of emphysema that occurs in individuals who do not smoke cigarettes and have a normal complement of alpha-1-antitrypsin.¹ Other explanations for this type of lung injury must exist in order to explain the bullous emphysematous changes that are occasionally witnessed in patients without the traditional risk factors.

Case Report

The patient, a 25-year-old white male, presented for evaluation of an abnormal chest radiograph.



Fig 1 — PA chest radiograph showing emphysematous bullae in both upper lobes of a 25-year-old patient.

Pulmonary Emphysema in a Nonsmoker

during strenuous activity. The patient was free of respiratory symptoms.

The patient had never smoked cigarettes or marijuana. He denied the use of illicit or recreational drugs. There was no history of exposure to infectious diseases or environmental toxins. Family medical history was unremarkable.

His physical examination revealed a height of 172 cm and a weight of 56.8 kg. Blood pressure and pulse were normal. Breath sounds were decreased bilaterally with hyperresonance to percussion. Mild expiratory slowing was evident. A loud pulmonic closure occurred during the second heart sound. All digits were mildly clubbed.

Hyperinflation of the lungs with increased residual volume were confirmed by the helium dilution method as well as by body plethysmography. Alpha-1-antitrypsin levels and sweat chloride levels were repeatedly within normal limits. A gallium scan of the patient was obtained early in the course of his evaluation and failed to show evidence of alveolitis. Electrocardiogram was abnormal in the QRS axis, which showed right deviation to 120 degrees. Arterial blood gas analysis was surprisingly normal.

He was subsequently evaluated by a referral center to determine his suitability for future lung transplantation and to seek a more precise etiology of his lung damage. The degree of emphysematous change was more accurately detailed by sophisticated technology, but the factors resulting in the alveolar-capillary destruction of this patient's pulmonary parenchyma could not be defined.

Discussion

The association of alpha-1-protease inhibitor deficiency with the development of panlobular emphysema has provided the current hypothesis that lung destruction resulting in emphysema results from an imbalance of intrapulmonary proteases and antiproteases. Alpha-1-protease inhibitor (alpha-1-antitrypsin) is the major antiprotease of the lower respiratory tract. By acting as a false substrate, it is capable of inhibiting neutrophil elastase, the major destructive protease. The resulting covalent bond is irreversible and inactivates both enzymes.² If the lung lacks an adequate supply of alpha-1-protease inhibitor, or if there is an overwhelming increase in neutrophil elastase, the alveolar walls may be damaged.

The major source of proteolytic enzymes is the pool of inflammatory cells in the lung. Al-

though neutrophils account for only 1% of the total inflammatory cells of the normal lower respiratory tract, they are the most important because of their ability to produce neutrophil elastase. If allowed to act unopposed, neutrophil elastase is capable of cleaving the elastin, collagen, and fibronectin that constitute the connective tissue matrix of the alveolar wall. The histiologic and physiologic abnormalities that result are those of human emphysema.^{3,5}

Alveolar macrophages account for 80% to 90% of the inflammatory cells in the normal lower respiratory tract. They release neutrophil chemotactic factors that stimulate neutrophils to release leukocyte elastase. These macrophages incorporate neutrophil elastase, resulting in a reservoir of active elastase that is released slowly and can degrade elastin. Macrophages also secrete a metalloenzyme that has the ability to digest and lower the concentration of alpha-1-protease inhibitor.^{3,4}

Additional antielastases such as alpha-2-macroglobulin and bronchomuco-protease inhibitor assist alpha-1-antitrypsin neutralize elastase. These protease inhibitors reside in the epithelium lining the lower respiratory tract and provide approximately 10% of the lung's antineutrophil elastase activity.⁴

Oxidants are also relevant to the pathogenesis of emphysema. Activated inflammatory cells release superoxide anion, hydrogen peroxide, and hydroxyl radicals. Environmental oxidant pollutants such as ozone and oxides of nitrogen have not been significant factors in the pathogenesis of human emphysema.⁵ The oxidants inhaled in cigarette smoke, however, represent a major factor in the occurrence of emphysema.^{4,6} Oxidation of alpha-1-protease inhibitor reduces the rate of its association with elastase by a factor of 2000.³

Several antioxidants are present in the lower respiratory tract to offset oxidant interaction with target molecules. Superoxide dismutase detoxifies superoxide anion and hydroxyl radicals, while catalase and glutathione inhibit hydrogen peroxide. Ceruloplasmin, a plasma copper transport protein, blocks inactivation of alpha-1-protease inhibitor induced by hydrogen peroxide and cigarette smoke. Vitamin E is the major membrane antioxidant that protects plasma membrane lipids from peroxidation, while vitamins A and C also have antioxidant properties.^{4,6} Methionine sulfoxide reductase is capable of reducing oxidized alpha-1-protease inhibitor, thereby restoring its activity as a tissue protector.³

In addition to a specific antioxidant activity, ceruloplasmin is important for connective tissue repair in experimental emphysema. The enzyme lysyl oxidase that catalyzes the cross-linking of elastin and collagen requires copper.⁶ Processes that interfere with the cross-linking function of lysyl oxidase can exacerbate the degree of emphysema by interfering with the capacity of the lung to repair itself.

These concepts provide the clinician with the mechanisms most commonly cited to explain the destruction of the alveolar capillary membrane that results in emphysema. They are also likely to be responsible for the destruction of lung parenchyma seen in our patient, although the inciting event is atypical. Because our patient was not a cigarette smoker and has a normal complement of alpha globulins, we will examine alternative explanations.

The current literature allows speculation that problems relating to differences in expression of neutrophil proteases or the inability to synthesize new connective tissue could be additional factors that promote premature bullous emphysema.

It is observed that interstitial pulmonary fibrosis and alpha-1-protease inhibitor deficiency are both associated with increased neutrophils in the lung, yet result in very different pathophysiologic changes. This has prompted researchers to assess the roles of proteases and oxidative products in determining the nature of the lung lesions in chronic neutrophilic alveolitis. Bronchoalveolar lavage (BAL) fluid from the lower respiratory tract of subsets of patients was assayed for neutrophil collagenase, elastase, and myeloperoxidase. In normal patients the lower respiratory tract fluid contained no active myeloperoxidase, collagenase, or elastase. In contrast, myeloperoxidase and active collagenase were found in patients with interstitial fibrosis, but elastase was not recovered. The BAL fluid from those with alpha-1-protease inhibitor deficiency was found to have active amounts of all three enzymes. This led to the speculation that the development of fibrosis versus alveolar wall destruction may be determined by differences in the expression of neutrophil connective tissue protease activity in the lung.⁷

In another study attempting to assess the role of tissue repair and the development of fibrotic or emphysematous lesions, investigators instilled Cadmium Chloride (CdCl₂) into the trachea of animals. This resulted in an acute increase in neutrophils. Despite the increase in oxidants and

elastases, the predominant lung lesion was found to be fibrosis. Since exposure to CdCl₂ had previously been reported to result in lesions similar to paracicatricial emphysema,⁸ the investigators speculated that the absence of emphysematous changes in their animals may have been related to the animal's ability to synthesize new connective tissue fibers.

To further substantiate this hypothesis, animals were given CdCl₂ and refed with a regular diet or a similar diet supplemented with B-aminopropionitrile (BAPN). This compound is a lathyrogen with the ability to inhibit the cross-linking of collagen and elastin and impair the formation of new connective tissue. Those animals fed the regular diet developed an acute inflammatory reaction that progressed to pulmonary fibrosis. Those animals that received the BAPN-supplemented diet developed alveolar wall destruction and bullous emphysema. These results suggest that the same lung insult may result in either emphysema or fibrosis depending on the host's ability to synthesize new connective tissue.⁹

An animal model of spontaneous emphysema was described that invokes an elastase-antielastase imbalance as part of its pathogenesis. The tight-skin (TSK/+) mouse has an autosomal dominant mutation characterized by multiple connective tissue abnormalities, increased thoracic size with enlarged lungs, numerous subpleural cysts and scattered bullae. These mice also have increased numbers of alveolar macrophages and neutrophils. Although circulating alpha-1-protease inhibitor was found in normal concentrations, the inhibitor found in the pulmonary lavage fluid was shown to be partially inactive.¹⁰ It is possible that a spontaneous genetic mutation could be responsible for the presence of the emphysematous changes in some patients without alpha-1-antitrypsin deficiency and who have never smoked tobacco.

Hereditary predisposition to bullous emphysema is supported by its association with the rare, but pathologically well defined, familial disorders. Observations of premature emphysema in humans with congenital disease and normal alpha-1-antitrypsin levels also include its occurrence in Salla disease, an autosomal recessive disorder of sialic acid metabolism;¹¹ in the unusual idiopathic nonarteriosclerotic cerebral calcification syndrome, an autosomal inherited disorder;¹² and in cutis laxa, a heritable elastin disorder.¹³

In summary, as the pathogenesis of premature emphysema continues to undergo extensive

Pulmonary Emphysema in a Nonsmoker

clinical investigation, an established hypothesis for our patient's lung destruction can only be speculative. Inherited problems relating to differences in expression of neutrophil protease or an inability to synthesize new connective tissue is an attractive explanation.

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DaCosta's Syndrome: Chronic Symptomatic Hyperventilation

Van Q. Nguyen, MD; Ryland P. Byrd, Jr, MD; Cheryl L. Fields, MD;
Thomas M. Roy, MD

In 1871, DaCosta published his observation of somatic symptoms preceded by significant hyperventilation.¹ More than a century later, the hyperventilation syndrome remains a poorly defined but common clinical condition.² Although familiar to most practitioners of medicine when it presents as an acute phenomenon, the diagnosis may go unrecognized in its chronic form. The ability of a chronic hyperventilatory state to mimic a life-threatening cardiopulmonary disease is not always appreciated.³

Introduction

The physical symptoms described by DeCosta in 1871 were scientifically linked to the act of involuntary hyperventilation in 1938. A number of somatic complaints such as breathlessness, chest discomfort, circumoral and peripheral paresthesia appeared to be adequately explained by the acute reduction in PaCO₂ resulting from overbreathing.⁴

Most practitioners who have treated acute hyperventilation accept that the complaints are physiologically appropriate for the clinical situation in which there is rapid dissociation of carbonic acid and excretion of bicarbonate stores from the blood and other organs. There is less awareness that predictable physical symptoms can occur during chronic respiratory alkalosis.²

The problem of chronic hyperventilation is not discussed in any detail in the major pediatric or medical textbooks.⁵ This important omission perpetuates the limited understanding of hyperventilation as a legitimate diagnosis. We present one example of chronic hyperventilation that mimicked a life-threatening pulmonary disease and review the current medical literature that may help the physician recognize this process.

Case Report

A 24-year-old female presented to her community hospital with complaints of shortness of breath. She was found to be tachypneic, tachycardic, and diaphoretic. Audible wheezing was documented without cough or sputum production. She did not subjectively improve with the administration of beta adrenergic agents, theophylline and corticosteroids. She was referred to the pulmonary service after being admitted to the intensive care unit for treatment of refractory asthma.

She had been diagnosed with hyper-reactive airways disease 6 months earlier by her primary care physician based on her history and presentation. She was intermittently treated with bronchodilators and steroids. Subjectively the patient denied any significant improvement with these agents. She had not performed spirometry or had arterial blood gas analysis prior to the diagnosis.

Her physical examination was unremarkable except for tachypnea with a respiratory rate of 20 breaths per minute and tachycardia of 110 beats per minute. Minimal wheezing was heard during auscultation, but forced inspiration to Total Lung Capacity did not worsen the adventitious sounds nor cause reflex coughing.

Her chest radiograph was normal and did not show evidence of hyperinflation or active disease. Her arterial blood gas analysis measured the PaO₂ at 90 mm Hg and a PaCO₂ at 33 mm Hg with a pH of 7.47. Her alveolar-arterial oxygen gradient was determined to be 17 mm Hg (5-20 mm Hg wnl). Serum electrolytes measured the bicarbonate level at 21 mEq/L. Complete blood count was normal without the presence of eosinophils in the peripheral smear. The patient's serum B-HCG level was normal.

Her hospital course was marked by a rather immediate cessation of symptoms which were ini-

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DaCosta's Syndrome

Table 1. Causes of Hyperventilation

Organic	Metabolic acidosis
	Sepsis
	Asthma
	Pulmonary embolus
	Interstitial lung disease
	COPD
	CNS lesions
	Liver disease
	Left ventricular failure
Physiologic	Severe pain
	Altitude
	Pyrexia
Drugs	Pregnancy and menses
	Aspirin
Psychiatric	ETOH withdrawal
	Anxiety or panic
	Depression
Idiopathic	Factitious
	Chronic Hyperventilation Syndrome

tially attributed to the medications administered. However, her arterial blood gas analysis during remission continued to show an identical alveolar-arterial oxygen gradient. Medications were gradually withdrawn without recurrence of symptoms. Five days after admission, flow-volume pulmonary functions were obtained which were normal. Because spirometry may be normal during a remission of asthma, a methacholine challenge test was performed 3 weeks after her discharge. This bronchial provocation test was normal.

Because the patient had normal pulmonary function, no difficulty with bronchial provocation testing, maintained normal gas exchange during exacerbation of her "asthma," alternative diagnoses were entertained. The observation of one of the authors (CLF) that the patient appeared anxious and sighed frequently during interviews led to close questioning about life stresses. It was determined that the patient was undergoing both financial and marital difficulties. A hyperventilation challenge test was performed in the pulmonary laboratory under the guise of measuring a direct MVV. The patient complained of recurrence of her "asthma" symptoms during this maneuver.

The diagnosis of hyperventilation syndrome was discussed with the patient. She was relieved to learn that she did not have a chronic life-threatening disease and agreed to repeat the hyperventilation challenge test a second time for confirmation. Her symptoms were reproducible each time

the PaCO₂ was lowered below 30 mEq/L. She has engaged in relaxation therapy and psychological counseling without recurrence of symptoms over a 10 month interval.

Discussion

The prevalence of chronic hyperventilation syndrome (HVS) among medical patients in an ambulatory setting is at least 10%.⁶ It is suggested that the condition is more common, but goes unrecognized and eludes definitive diagnoses.⁷ This is understandable considering the number of other diseases that have hyperventilation as a part of their pathophysiology (Table 1). It would appear that the only safeguard is to maintain an increased awareness for the possibility of HVS.

Despite a wide body of literature, there are no universally accepted criteria for the diagnosis of HVS.⁸ Hyperventilation in this context implies alveolar ventilation in excess of metabolic needs with resultant hypocarbia. This promotes changes in the membrane potential of all excitable tissues and lowers the action-potential threshold. The excitability of muscles and neurons increases. The plasma concentration of free calcium ion and the plasma potassium concentration are diminished which increases the excitability of the neuromuscular junction. A generalized vasoconstriction may occur that alters cerebral and coronary blood flow.

The resulting symptoms of HVS are numerous. The majority of patients have complaints referable to the cardiovascular, neurologic or respiratory systems. Typical symptoms include breathlessness out of proportion to physical effort, chest pain, dizziness, paresthesia, weakness and fatigue, and palpitations.⁷

It is generally accepted that with sufficient hyperventilation all persons will develop some symptoms. Patients with HVS appear to develop symptoms more rapidly, however, because a chronically low PaCO₂ keeps the patient vulnerable to even mild increases in ventilation.^{2,7}

These patients have a well defined ventilatory profile. They breathe with an irregular pattern that causes frequent changes in their baseline tidal volume. This pattern is evident even when the patient is at rest and apparently unstressed.⁹ Intermittent deep sighing or yawning is common and resting hyperventilation can often be observed. Patients are frequently unaware that they are hyperventilating and react with disbelief when so informed.

Physiologic studies suggest that patients with this disorder have delayed recovery of alveolar carbon dioxide levels after cessation of voluntary deep breathing.¹⁰ Other investigators propose that these patients have a respiratory center that is genetically hypersensitive to the CO₂ stimulus to breathe.¹¹

A major problem in clinical medicine is identifying HVS that mimics a life-threatening disorder that might require invasive diagnostic procedures or dangerous therapeutic interventions. This most commonly occurs when the differential diagnosis includes asthma, pulmonary embolism, or symptomatic coronary artery disease. The hypocapnia induced by overbreathing may cause bronchoconstriction with audible wheezing that is mistaken for asthma.¹² Chest pain in the context of breathlessness may suggest the possibility of pulmonary embolism, angina, or myocardial infarction.¹³

A hyperventilation provocation test is frequently helpful in demonstrating to the patient the association of their symptoms with hyperventilation. This test requires voluntary hyperventilation for 2 to 3 minutes and should only be performed in a well supervised and equipped medical setting. Documentation of hyperventilation and hypocarbia is performed by monitoring end-tidal CO₂ levels by capnography or by arterial blood gas analysis. The patient's recognition of their presenting complaints while hypocapnic is the criteria for a positive test. If precautions are taken to avoid testing patients with epilepsy, cerebral vascular disease, or coronary artery disease, the provocation test is safe and often helpful. It is a useful tool for confirming the HVS when positive, but lacks sensitivity and specificity as the sole diagnostic maneuver.¹⁴ Patients with chronic HVS will have a characteristic slow post-provocation test recovery to baseline PaCO₂ levels that may be helpful.¹⁰

In patients with chronic hyperventilation, all measurements of pulmonary function that are independent of voluntary effort such as compliance, gas distribution, and diffusing capacity, are normal. Importantly, HVS patients without true cardiopulmonary pathology have an increase in PaO₂ that accompanies the decrease in PaCO₂. Simple calculation of the alveolar-arterial oxygen tension gradient (A-aDO₂) will be normal and is often sufficient justification for avoiding an extensive workup for pulmonary embolism.

Since baseline pulmonary function may be normal in asthmatics during remission, a bron-

chial challenge test may be necessary to confirm or dismiss the diagnosis of hyper-reactive airways. There is ample evidence that the two conditions can coexist. There is also information that demonstrates that control of HVS will decrease the frequency of overt attacks of bronchospasm.¹²

The chest discomfort of HVS is sometimes accompanied by changes in the electrocardiogram. These include sinus tachycardia with a downward shift of the ST segment and flattening of the T waves with an apparent prolongation of the QT interval. Less commonly, isolated T-wave inversions and marked ST depressions may occur. The mechanisms by which hyperventilation interferes with myocardial repolarization remain speculative and are probably multifactorial.¹⁵ Cardiovascular disease may be identified by noninvasive studies if the physician is aware that the EKG changes are evident only during hyperventilation with hypocarbia. Of critical importance, the ST shifts that simulate ischemic changes are not induced, but lessened, by exercise.¹⁶

A main stumbling block in the understanding of HVS revolves around the nature of the stimulus for the patient's excessive drive to breathe. If it is a genetically determined derangement of the sensitivity of the respiratory drive to CO₂, as some evidence suggests, then it can stand alone as a medical disorder. If it is merely an exaggerated response to fear, then it overlaps with the psychiatric diagnosis of panic disorder.⁸

Although anxiety, fear, and panic precipitate hyperventilation in some patients, it is important to recognize that a reciprocal relationship may also be operative. Not only can anxiety cause hyperventilation, but the perceived symptoms associated with hyperventilation may induce anxiety. The potential for a continuing cycle is apparent. It is noteworthy that in some studies formal psychiatric symptoms are absent in one-half of the patients identified with HVS.^{2, 17}

A combination of treatment methods is proposed for the patient with HVS.¹⁸ Reassurance is important but often difficult to accomplish in patients who have originally been misdiagnosed or treated for a life-threatening disorder. This is especially true after prolonged testing or invasive procedures have been required to establish the correct diagnosis.

Education is often an easier task since many patients will experience their symptoms with the hyperventilation provocation test. Once an association is established, the patient is more receptive to relaxation therapy and breathing ex-

DaCosta's Syndrome

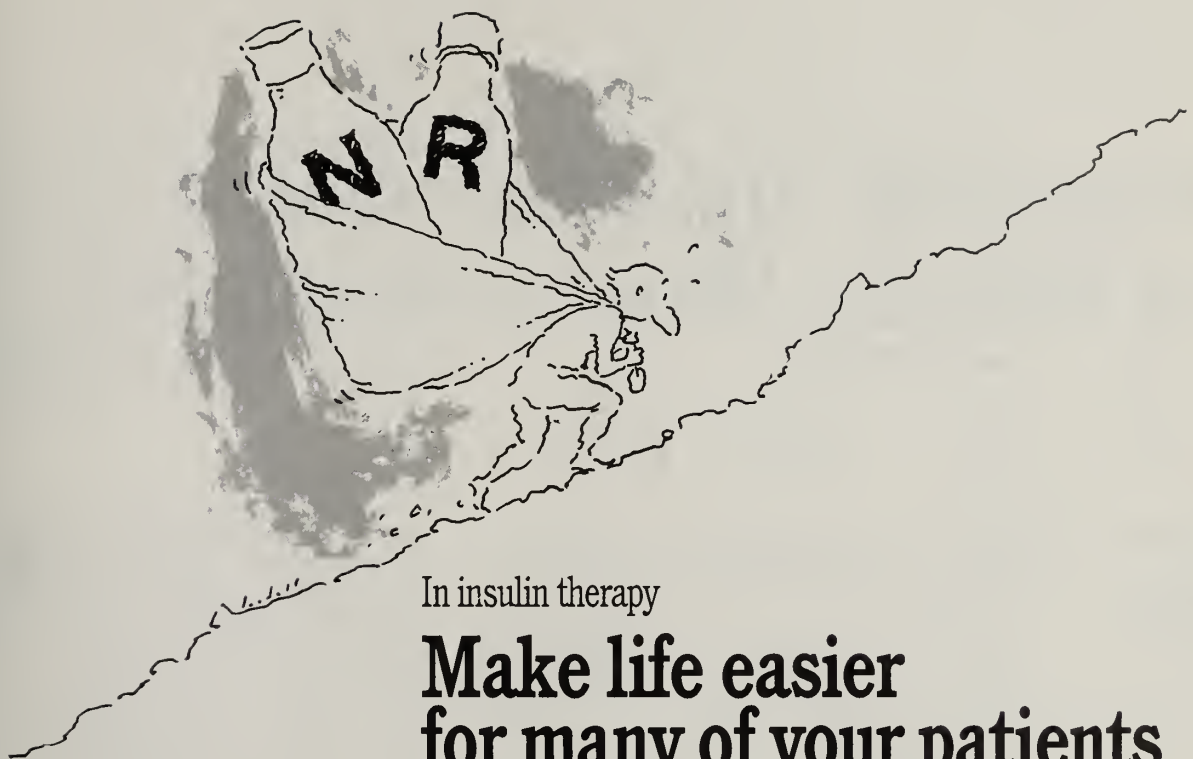
ercises to adjust their breathing habits. Diaphragmatic breathing is taught in the same fashion that we instruct our COPD patients.

Occasionally, patients will benefit from beta-adrenergic blockers during their retraining efforts.¹⁹ This medication will lessen the peripheral symptoms of anxiety and decrease the respiratory stimulation of catecholamines. If significant psychopathology is identified that might require anxiolytics or antidepressants, a psychologist or psychiatrist may be helpful.¹⁸

In summary, hyperventilation is a common disorder that is often difficult to recognize because of its ability to mimic other disorders. While the relationship between HVS and anxiety remains unclear, some correlation between them is expected. An early and correct diagnosis of HVS is of prime importance in the treatment of this disorder. Greater awareness of the chronic form of HVS should help the clinician to limit unnecessary and potentially harmful medical testing.

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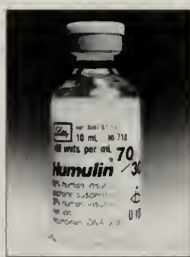
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Nonsteroidal Anti-Inflammatory Drug Induced Renal Syndromes

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Nonsteroidal anti-inflammatory drugs (NSAIDs) may cause acute renal failure from unopposed vasoconstriction or acute interstitial nephritis. NSAID induced hemodynamic renal failure is characterized by sudden oliguria, often with decreased fractional excretion of sodium, occurring in patients with decreased effective circulating fluid volume or preexisting renal disease. Allergic interstitial nephritis from NSAIDs may occur at any time during therapy with the drugs and may present as renal failure with or without the nephrotic syndrome. Although chronic renal failure has been reported, both renal syndromes usually resolve when treatment with the NSAID is discontinued.

Renal function should be measured soon after initiation of therapy in patients at risk for the hemodynamic effects of the drugs and periodically thereafter. Patients should be warned about the potential toxicity of the drugs.

Nonsteroidal anti-inflammatory drugs (NSAIDs) are among the most frequently prescribed medications in clinical practice. The number of drugs available for use and their indications have increased since their effect on prostaglandin synthesis was first demonstrated in 1971.^{1,2} In addition, the present availability of NSAIDs as nonprescription drugs has made them more widely available. As many as 40 million Americans may use NSAIDs regularly.³ This large, at risk population requires that physicians be increasingly aware of the potential adverse effects of the agents. The purposes of this review are to describe the renal syndromes caused by NSAIDs, and to provide practical clinical guidelines for the assessment and management of patients treated with the drugs.

Nonsteroidal anti-inflammatory drugs (NSAIDs) cause a variety of effects on renal func-

tion. These side effects can be classified on the basis of the clinical syndromes that they manifest. Renal syndromes produced by NSAIDs can be divided into those caused by the drugs' pharmacological action on the kidney and those which are related to direct nephrotoxicity. NSAID induced pharmacologically mediated changes in renal function result from the expected consequence of renal prostaglandin synthesis inhibition. Direct nephrotoxicity of the drugs results when individuals develop interstitial nephritis.⁴

NSAID Induced Renal Syndromes

Prostaglandins are synthesized from arachidonic acid by cells in the renal cortex and medulla, and are removed from the renal microcirculation through metabolism in the renal cortex.⁵ Prostaglandins PGE₂, PGF₂ α and PGI₂ are potent vasodilators, while thromboxane A₂ is a vasoconstrictor. These fatty acids are referred to as autocooids, because they are produced and metabolized locally by the kidney where they exhibit their effects autoregulating renal blood flow, renin release, tubular ion transport, and water metabolism.⁶⁻¹⁰ The renal consequences of prostaglandin synthesis inhibition are shown in Fig 1.

The renal microcirculation is constantly subjected to vasoconstricting stimuli including angiotensin, catecholamines and renal nerve activity. When the potentially vasodilating effects of PGE₂, PGF₂ α and PGI₂ are eliminated by the use of NSAIDs, renal plasma flow and the glomerular filtration rate decrease. Prerenal azotemia and renal failure from unopposed renal vasoconstriction result. The features of this renal syndrome are listed in Table 1.

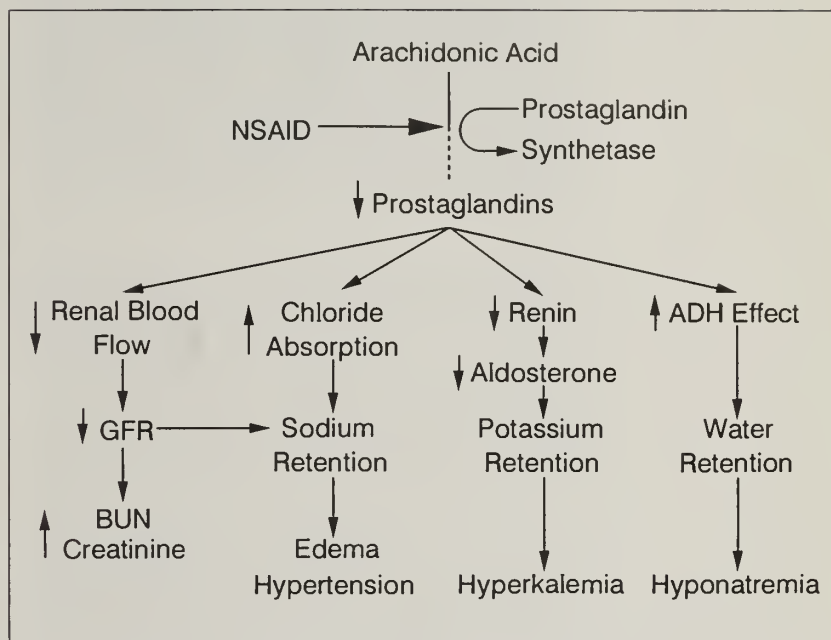
Most patients with acute renal failure from NSAID induced renal vasoconstriction experience a sudden decrease in their glomerular filtration rate. Within the first 24 to 48 hours of treat-

Table 1. Acute renal failure from NSAID induced vasoconstriction

- Oliguria
- Sudden onset
- Low FE_{Na}
- Known risk factors
- Reversible

Table 2. Risk factors for hemodynamic renal failure during NSAID therapy

- Volume contraction
- Congestive heart failure
- Cirrhosis
- Shock
- Sepsis
- Advanced age
- Pre-existing renal disease

**Fig 1 —** The effects of NSAID induced inhibition of prostaglandin synthetase on renal physiology.

ment with the NSAID, the serum creatinine increases and urine output decreases. The urinalysis is usually free of protein, cells, or casts.¹¹ The fractional excretion of sodium (FE_{Na}) is often less than 1%, demonstrating avid sodium retention and suggesting the prerenal nature of the azotemia.¹² This hemodynamic deterioration in renal function is reversible. When recognized early, patients usually do not require dialysis.

Patients at the greatest risk of developing acute renal failure from NSAID induced vasoconstriction are those who require the vasodilating effects of prostaglandins to preserve renal blood flow and glomerular filtration. Table 2 lists known and suspected risk factors for developing hemodynamic renal failure during NSAID therapy. Ineffective circulating fluid volume is the unifying feature that leads to increased renin and angiotensin, and unopposed vasoconstriction in these NSAID treated patients.

Sodium retention is the most common renal effect of NSAID therapy.¹³ Prostaglandins affect sodium excretion indirectly by altering renal hemodynamics and directly through their effects on the renal tubule. Inhibition of renal prostaglandin production decreases renal blood flow from unopposed renal vasoconstriction and results in increased proximal tubular sodium reabsorption.

In addition, decreased PGE_2 synthesis results in enhanced chloride and sodium reabsorption in the ascending limb of the Loop of Henle.¹⁴ In patients with normal cardiac and renal function, sodium retention is usually temporary, mild, and of little clinical significance. In patients with pre-existing renal disease, congestive heart failure, or other high renin states, edema and hypertension may result.

Prostaglandins PGE_2 and PGI_2 stimulate renin release.¹⁵ By inhibiting synthesis of these prostaglandins, NSAIDs decrease renin generation and aldosterone production. Hyporeninemic hypoaldosteronism diminishes potassium secretion. In addition, decreased delivery of sodium to the distal nephron because of avid proximal tubular sodium reabsorption further limits distal potassium secretion. These effects can result in hyperkalemia.¹⁶ Patients with decreased renal function and Type IV renal tubular acidosis are at particular risk of this side effect. NSAIDs must be used with caution when given concurrently with other drugs known to decrease renal potassium excretion, including potassium sparing diuretics and angiotensin converting enzyme inhibitors.

Prostaglandins inhibit the effects of antidiuretic hormone on the collecting duct. Diminished renal prostaglandins in patients taking

Drug Induced Renal Syndrome

Table 3. NSAID induced allergic interstitial nephritis

- Proteinuria
- Edema
- Variable onset
- Idiosyncratic

NSAIDs results in enhanced water reabsorption. Hyponatremia is not common in patients with normal cardiac and renal function taking NSAIDs. However, individuals with some other impairment of free water excretion are at risk of developing hyponatremia. These include patients with decreased renal function, heart failure, and those taking diuretics.

Acute interstitial nephritis has been reported as a direct effect of NSAIDs.¹⁷ As outlined in Table 3, in contrast to those NSAID effects related to the inhibition of prostaglandin synthesis, nephrotic range proteinuria is the most common clinical

feature of this syndrome. Rash, eosinophilia, or eosinophiluria occur much less frequently. Renal failure requiring dialysis occurs in as many as a third of patients.¹⁸

As shown in Fig 2, renal biopsy of patients with NSAID induced acute interstitial nephritis reveals intense mononuclear cell infiltrates and interstitial edema. Few changes in glomerular histology are seen on light microscopic examination. However, swelling of the glomerular epithelial foot processes can be seen with electron microscopy. Immunofluorescent stains rarely demonstrate immunoglobulin or complement deposition in the kidney.

This syndrome is idiosyncratic and can occur any time after initiation of NSAID treatment. There are no well established risk factors. Recovery is usual when exposure to the NSAID ceases, but continued renal impairment following this form of interstitial nephritis has been reported. Corticosteroids have been used to decrease proteinuria and shorten the duration of renal failure. However, the benefits of this regimen are un-

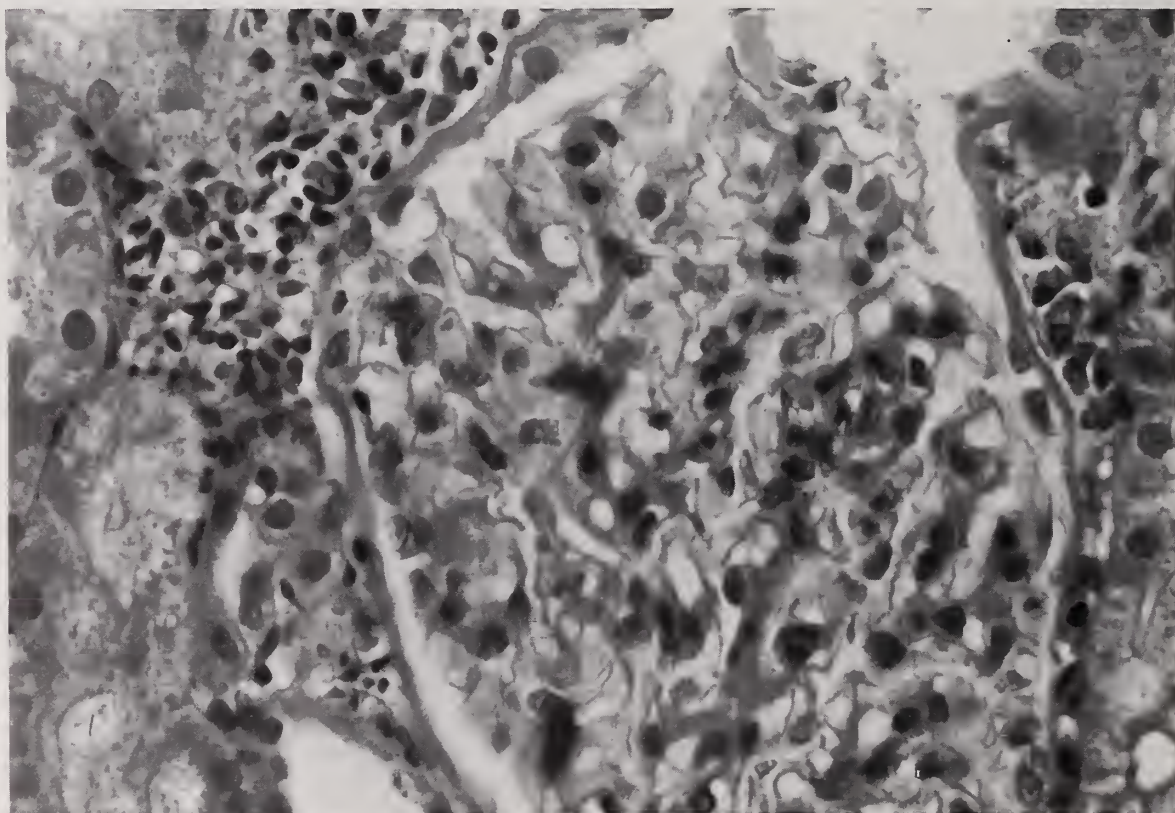


Fig 2 — Light photomicrograph of renal tissue from a patient with NSAID induced acute interstitial nephritis. Glomerular histology is normal. Round cells infiltrate the interstitium.

proven.¹⁸

Although hemodynamic changes in renal function and acute interstitial nephritis are more frequently reported, chronic renal failure associated with NSAID use has also been described. Several cases of interstitial fibrosis or papillary necrosis have followed acute interstitial nephritis.¹⁹⁻²¹ Increased risk for the development of chronic renal disease is associated with daily NSAID use, particularly in older patients and those with vascular disease.^{22,23}

Summary and Recommendations

Two distinct renal syndromes occur in patients taking NSAIDs. Hemodynamic impairment of renal function is the consequence of the pharmacologic inhibition of prostaglandin synthesis. This syndrome may include acute renal failure, sodium retention, hyperkalemia, and hyponatremia. Patients with decreased effective circulating fluid volume and high renin states are at increased risk, and return of renal function after cessation of NSAID use is common.

In contrast to the pharmacologically mediated effects of NSAIDs on the kidney, acute interstitial nephritis is idiosyncratic. This syndrome is less frequently seen, but more commonly results in renal failure requiring dialysis. Surveillance studies show that both syndromes are rare.²⁴

No special laboratory measurements are necessary prior to the use of NSAIDs in most patients. However, to avoid potential adverse renal effects, renal function should be measured in patients with increased risk of developing NSAID induced hemodynamic renal insufficiency before treatment with the drug is initiated. These measurements should include BUN, serum sodium, potassium, and creatinine concentrations. Blood pressure should be measured and volume status assessed by examination for signs of heart failure, dehydration, ascites, and edema.

Since hemodynamic renal insufficiency usually occurs soon after initiation of NSAID treatment, these measurements should be repeated within a few days of beginning therapy with the drugs and at infrequent intervals during long-term use. Because the occurrence of interstitial nephritis cannot be predicted, all patients receiving NSAIDs should be cautioned about the development of edema which could be a sign of the nephrotic syndrome. Older patients and those with vascular disease are at increased risk of developing chronic renal failure while using NSAIDs. Renal function should be measured more frequently in these patients.

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Health Care Is Too Important to Be Left to the Physicians

Of course paraphrase, albeit facetiously I hope, the famous comment made by a prime minister of World War I, "That war was too important to be left to the generals."

In the arena of health care everybody's an expert. From the politician in search of a vote from his constituents, the insurance firms to improve their bottom line, the hospital administration in a joint venture with both God and the devil to make the facility survive the cut, and finally to industry that zigs and zags back and forth between insurance carriers to both lower their premium and to limit access to care.

But for heaven's sake, don't ask the doctors, for we are the enemy. We create the care, admit to the hospitals, initiate medical and surgical judgement, and order tests to make the diagnosis. Why, we are the guys that spend the money that everybody is hollering about.

Well, who can we change to make the system better? Can we change the patient and tell him less is more? Every other player in the field has gone through a transformation and adjustment in medical care, either real or perceived, except for the patient. The patient knows what he has had and wants to keep it that way. They would like to have no deductible and no co-payment. They would like discharge from the hospital upon convenience and

"Oh, how I would like to interview the senators, representatives, and their aides who in 1965 wrote the federal mandate for Medicare."

instant readmission if their symptoms have not resolved to their satisfaction while home.

Can we reeducate the patient and/or health care consumer not to use the hospital emergency room as a place for casual routine care? It has been well documented that private care in an office setting is vastly less expensive than care in the emergency room of a hospital or even in a free-standing, immediate care center. Two reasons that come to mind as to why a person would choose an emergency room over private office care are:

1. Care can be obtained in late afternoon or night and several hours of daily wages are not lost.
2. What constitutes an emergency

"In the arena of health care everybody's an expert."

in the eyes of the patient is often vastly different from the viewpoint of the physician giving the care at the moment.

I have just finished reading an intriguing book titled, "The Other Side of the Hill," written by B. H. Liddell Hart, the famous military historian. In the book the author gives examples of conversations he had with German generals who survived World War II. Rundstedt, Model, Keitel, Manteuffel, Jodl, and Manstein were all famous leaders of Germany's land forces on the eastern and the western fronts during the War. To a man, they felt that Hitler's interference and intransigence toward military strategy crafted many of the great debacles suffered by the German Wehrmacht (to the allies advantage).

Oh, how I would like to do a Liddell Hart and look at the other side of the hill. Oh, how I would like to interview the senators, representatives, and their aides who in 1965 wrote the federal mandate for Medicare. But after 27 years, who is still alive to compare the intent of the 1960s to the realities of the 1990s? Talk about missed opportunities!

Health care too important to be left to the physician? Absolutely not! It only seems that way to those in the safety of the rear echelon who have not the travail of daily patient care.

Milton F. Miller, MD

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Are you concerned about the effects of family violence and victimization within your community?

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Successfully defending a brain-damaged baby case is the courtroom equivalent of pitching a no-hitter. Because the "sympathy factor" can add millions to a jury's award, many insurance carriers would rather settle than fight.

Not so the P-I-E Mutual Insurance Co. of Cleveland, Ohio, and the 4-year-old law firm—Lauson, Maynard, Tuschman & Kalur—that does all its defense work. In 21 brain-damaged baby cases it has defended for the doctor-owned company, its record is a remarkable 19-1, the last a hung jury. In 1988, its record all scored real wins, a loss—all malpractice cases.

There's more to those numbers than luck. "Or even legal skill," adds JMT&K founding partner Aaron Jacobson, who was one of Ohio's leading plaintiff lawyers before he, Larry E. Rogers, Herbert S. Bell, M.D., and 70 other Cleveland doctors formed P-I-E in 1975. "It's the concept behind the firm that makes it work. Physician specialty panels review every lawsuit to decide whether the defendant deviated significantly from the standard of care. If he did, we pay. If he didn't, we defend. Makes no difference whether it's a \$5,000 or a \$5 million case. We label it No pay. That policy has resulted in a lot of cases being dropped. Perhaps more important, it's

DON'T YOU WISH THESE DEFENSE LAWYERS WERE YOURS?

This big, multistate firm rarely loses a case. But it's more than luck, or even legal skill, that's behind its enviable record.

By Howard Eisenberg

discouraged the filing of many other cases. Plaintiffs' attorneys have learned that we're fair negotiators when our clients are in the wrong, but won't back down when he's right."

That approach pays off. "According to the most recent report I've seen from the General Accounting Office," says Larry Rogers, P-I-E president and CEO, "in 1984, about 57 percent of medical malpractice claims were ruled without payment. Through 1988, we've closed an average of 78 percent of our cases without a dime changing hands. And it's my understanding that, without including defense costs, St. Paul Fire and Marine Insurance Co.'s 1988 average gross payout for cases closed in Ohio with payment was \$52,500. Our comparable figure was about \$10,000 below

theirs. That's partly what we can sell an OB/Gyn specialist in Ohio—an industrial state that ranks among the most litigious—\$1.2 million in coverage for just \$26,400."

The unique marriage of P-I-E and JMT&K has been so successful that the carrier has expanded into five other states: Indiana, Kentucky, Maryland, Missouri, and West Virginia. Where P-I-E goes, there goes JMT&K, with nine branch offices to date. The firm has 60 trial attorneys, and may well be the nation's largest devoted well-though exclusively to medical malpractice defense.

Could the insurer-defender symbiosis, if duplicated by other doctor companies, make a significant contribution to reducing malpractice litigation nationwide? An up-close look at

how JMT&K operates may help to answer that question.

Every lawyer develops a medical specialty

"Our firm's lawyers read more medical books than law books," says P-I-E Vice President Gerald V. Oppenorth, himself a veteran defense attorney. Robert Maynard explains, "New cases are discussed at our weekly staff meeting, so that every lawyer is familiar with every case. But we assign cases to our attorneys according to medical specialty. They're well-versed in their fields, so they don't have to reinvent the wheel with each case."

Last year, the firm's OB/Gyn specialist, attorney Jerome S. Kalur, who had won 16 consecutive brain-damaged baby cases, faced one of his toughest challenges when he defended a GP

who'd attempted a malpractice delivery that ended in a C-section section and a severely brain-injured baby. Recalls Kalur, "I didn't think the doctor had caused the damage, but our position was weakened by the fact that he didn't have malpractice privileges. Based on that departure from the standard of care, our doctor panel voted to settle, and, since the hospital was also involved, a combined sum of \$1.5 million was offered. Plaintiffs turned us down flat."

"I wanted to depose the doctor who'd been involved in the mother's care during her hospitalization, but the attorney for the plaintiff baby insisted it would violate the mother's physician-patient confidentiality. That privilege would terminate automatically when her medical

The winning firm is four founders at Cleveland's 8th District Court of Appeals (from left): Jerome S. Kalur, Aaron Jacobson, James M. Tuschman, and Robert Maynard.

records were introduced at the trial end of the plaintiff's case. Meanwhile, I was in the courtroom having to tell the jury, 'It couldn't have been the jury.' Without offering malpractice, without offering them another reasonable brain-damage theory."

Fortunately, the plaintiffs rested their case on a P-I-E affidavit, giving JMT&K time for a weekend rally. "Twenty minutes later," says Kalur, "I was in the hospital pathologist's office with an order permitting me to view the mother's placental slides." Meconium staining had been charted, and Kalur had a hunch that fetal distress had begun long before the for-



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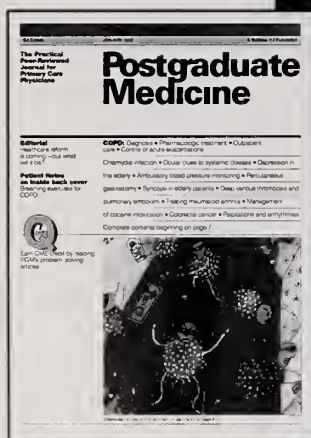
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McDowell House

"It is a great history lesson for school children, adults, and most especially young people studying the medical profession."

Dr Ephraim McDowell made medical history in the small village of Danville, Kentucky, on December 25, 1809. On that day he removed a 22½ pound ovarian tumor from 46-year-old Jane Todd Crawford of Green County, Kentucky. This operation, done without benefit of anesthetic or antisepsis, had heretofore been thought impossible. McDowell's success thus paved the way for modern abdominal surgery.

Ephraim McDowell was born in Rockbridge County, Virginia, November 11, 1771, the ninth of the 11 children of Samuel and Mary McClung McDowell. Ephraim came to Danville at age 12, after the Revolutionary War. His father had

fought with George Washington and had been a member of the Virginia House of Burgess with Washington. Samuel had been appointed a commissioner to settle land claims; and he would later serve as Chairperson of the Committees to write the Constitution for the Commonwealth. The dream of a separation from Virginia was realized in 1792.

No doubt young Ephraim received the best education that those early times and frontier conditions afforded, an education that according to our present standards would be considered limited. In his 19th year he went to Staunton, Virginia, to study with Dr Alexander Humphreys, a

graduate of the University of Edinburg. He would persuade his pupil to follow him there to study. Ephraim studied at the University of Edinburg in 1793 and 1794.

In 1795 Dr McDowell and Dr Adam Rankin opened an Apothecary Shop, the first west of the Alleghenies. The Governor's daughter, Sarah Shelby, became his bride in 1802. They lived in the house on Danville's Second Street, which is now restored as a museum. They had nine children; five lived to adulthood. Dr McDowell died in June 1830 of something they called cramp colic. Today we believe that this was a ruptured appendix.

On December 13, 1809, Dr

McDowell was called to Green County to see a Mrs Jane Todd Crawford, the wife of Thomas Crawford. For a time Mrs Crawford had been thought to be pregnant with twins, but as she had far exceeded the usual period, it had become evident that some other condition existed. Dr McDowell examined Mrs Crawford and reported that she had an ovarian tumor, a condition that would cause a very painful death. He told her there was nothing he could do to help her. She must have begged him to do something. He finally told her if she would come to his home in Danville, he would try to operate and remove the tumor. He returned home and she followed him on horseback a few days later. Her trip was 60 miles long and took 3 days. She arrived at his home a few days before Christmas, exhausted and her abdomen very badly bruised. He put her to bed for a few days, and then on Christmas morning, 1809, he was prepared to operate. He strapped her to a table in an upstairs bedroom and began a 25-minute operation. According to his

"The House has been primarily furnished by the AKMA, which continues to support the furnishing fund every year."

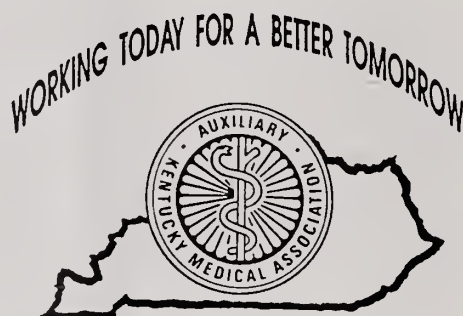
own report, she was awake and recited Psalms while he was removing a 22½ pound tumor. She was up making her bed in 5 days, and returned home 25 days after the surgery. She lived 32 years longer. For this operation, Dr McDowell is known worldwide as "The Father of Abdominal Surgery."

Dr McDowell's home in Danville has been restored to give honor to such a great surgeon. It is also a great history lesson for school children, adults, and most especially young people studying the medical

profession. The House was purchased in 1935 by the KMA for restoration. It was given to the state of Kentucky, who restored the house with the assistance of the WPA. In 1949, the house was deeded back to the KMA. Today it is operated as part of the Ephraim McDowell-Cambus Kenneth Foundation. The House has been primarily furnished by the AKMA, which continues to support the furnishings fund every year.

Nineteen ninety-two is an important year at McDowell House and in the state of Kentucky. We celebrated Kentucky's Bicentennial with a McDowell-Shelby-Crawford family reunion at the House on June 5-7. Nearly 100 family members attended the festivities. Everyone was invited to join the family members for lunch or dinner in the garden on Saturday, June 6. If you missed the celebration, we do hope you will have an opportunity to tour the House sometime this year.

Carol Johnson
AKMA McDowell House Director



If you or your spouse are not currently members of the AKMA, please join us by sending a check for \$40.00 to:

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AKMA Executive Secretary
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AUGUST

8-14 — 11th Annual Scientific Meeting and Exhibition of the Society of Magnetic Resonance in Medicine; Berlin, Germany. Contact: SMRM, 1918 University Avenue, Suite 3C, Berkeley, CA 94704; 510/841-1899; FAX 510/841-2340.

SEPTEMBER

3-5 — Perinatal Medicine; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

19 — "Diabetic Retinopathy" presented by N. D. Radtke, MD and Humana Hospital Audubon. Category I of the AMA Physician's Recognition Award, 4.0 hours. Contact: Cathy Edens, 240 Audubon Medical Plaza, Louisville, KY 40217; 502/636-2823.

25-26 — 5th Annual Rehabilitation Management for the Primary Care Physician; Radisson Plaza Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

25-26 — 6th Annual Multispecialty Oculoplastic Surgery Symposium — A conjoint symposium by specialties involved with the management of problems of the midface and ocular adnexa; Marriott's Griffin Gate Resort, Lexington, KY. Contact: Julie Burlew, RN, The Center for Advanced Eye Surgery, Humana Hospital-Lexington; 606/268-3769.

OCTOBER

25-30 — 23rd Family Medicine Review, Session III; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

NOVEMBER

8-12 — 96th Annual Meeting of The American Academy of Ophthalmology; Dallas Convention Center. Contact: The American Academy of Ophthalmology, Meetings Dept, PO Box 7424, San Francisco, CA 94120-7424; 415/561-8500.

12-15 — Southern Medical Association's 86th Annual Scientific Assembly; San Antonio, TX. Contact: SMA's Member Services Center; 800/423-4992; or 205/945-1840.

MARK YOUR CALENDAR

**142ND ANNUAL
MEETING
KENTUCKY MEDICAL
ASSOCIATION
SEPTEMBER 14, 15, 16, 17
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COMMONWEALTH
CONVENTION CENTER
LOUISVILLE**

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MEETINGS OF THE HOUSE
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ments for childhood cancer and has helped save the lives of thousands of children around the world. But the battle has just begun.

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The President Has Been Shot

Confusion, Disability, and the 25th Amendment in the Aftermath of the Attempted Assassination of Ronald Reagan

Herbert L. Abrams, MD
W. W. Norton & Company, Inc.
500 Fifth Avenue
New York, NY 10110

The original constitutional provisions governing laws of succession to the Presidency are found in Article II, Section 1, Clause 6 of the Constitution. The Twentieth Amendment of 1933 pertained to pre-inauguration death of the President and the Twenty-fifth Amendment ratified in 1967 deals with succession to the Presidency or its powers in the case of death or incapacity of the President. This fascinating factual and narrative book involves the assassination attempt on Ronald Reagan by John Hinckley and the subsequent events during his disability. With a medical perspective and an anti-nuclear bias, Dr Abrams describes the sobering reality that the exercise of power and possible destruction can be shifted into a number of players' hands. President Reagan's doctor, Dr Daniel Ruge, as well as the staff at George Washington University Hospital, were not only attendings, but also contributed to the decisions of power brokerage at some very critical times. That the succession lines were already drawn by the Constitution seemed of less relevance than the judgement of Reagan's intimates.

Dr Abrams is an able storyteller, and those present support his version of the incidents. His concern for nuclear misjudgement and his desire to extirpate the atomic weaponry from all potential users influenced his writing throughout. That Reagan incapacitated could exercise such potential for Armageddon, with the fingers on the trigger not being his, is breathtaking and frightening. Reading

this story is like reliving the incident, but with details that only those behind the doors could have known. History repeats itself and the vulnerability of the Presidential armor is apparent. Dr Abrams emphasizes that not death, but disability may be the malefactor, so long as nuclear armaments are at governmental beck and call. Whether hawk or dove, soft on defense or waving a white flag at the "nukes," all of us need to read about what government, and particularly elected officials, do with our Constitution.

Strategies to Control Tobacco Use in the United States: A Blueprint for Public Health Action in the 1990s

U.S. Department of Health and Human Services
Public Health Service
National Institutes of Health
National Cancer Institute
NIH Publication No. 92-3316
October 1991

Editor: Donald R. Shopland
Smoking & Tobacco Control Coordinator
National Cancer Institute
EPN Room 241
9000 Rockville Pike
Bethesda, MD 20892

This is the first of a new series of scientific monographs on smoking and tobacco control. This multi-authored volume is somewhat retrospective, chronicling the 40 or so years of public health work against smoking. Chapter 2, written by Drs Jerome Schwartz and Beti Thompson, reviews the evolution in strategies, from the earliest aimed to the individual to the later sociologic focus. During the 1950s the media assumed the responsibility of warning

people of the dangers of smoking. Nevertheless, powerful advertising messages from the tobacco industry effectively presented the opposing point of view and perpetuated the success of tobacco promotion. The Federal Communication Commission changed the game by ruling that all radio and television stations had to present information against smoking. During the 1980s the National Cancer Institute sponsored over 100 studies to document smoking hazards and relate this information to the clinical experience being developed. These so-called "interventional trials" evolved to balance the success of research production with delivery of the message to the public.

Subsequent chapters detail different approaches to both the individual and to the social environment. Environmental changes complemented by programs supporting individuals at different stages of smoking control and cessation are the basis for modern strategies. Under the umbrella of the NCI, multiple programs have developed. The specifics of these programs are explained in great detail, with multiple useful graphs and other pictorial material.

The final chapter discusses the American Stop Smoking Intervention Study for Cancer Prevention (ASSIST) program. This is the largest and most comprehensive smoking control project yet to be created and its primary objective is to reduce smoking prevalence to 15% or less of the population by 2000. At this point some 90 million people are targeted.

Multiple references and a comprehensive index end the book and signify the scientific quality of this tome. Kentuckians and their physicians are coming to grips with the realities of tobacco use. Planning for the future with less tobacco use, as is forewarned in this book, will enhance our place in the national picture.

Stephen Z. Smith, MD
Book Review Editor



Medical Challenges In An Age Of Risk

KMA Annual Meeting • Sept 13-17 • Hyatt Regency
Commonwealth Convention Center • Louisville, KY

KMA returns to the completely remodeled Hyatt Regency Hotel and Commonwealth Convention Center in downtown Louisville for this 142nd Annual Meeting. These two great facilities hosted KMA's meeting for the first time in 1990 which resulted in a record registration of over 2,550 attendees.

Hotel and Convention Center

The Hyatt Regency Louisville, located at 320 West Jefferson, is a luxurious 20-story atrium hotel overlooking the Ohio River in the heart of Louisville's business and entertainment district. The Hyatt features The Trellis, a full-service restaurant located on the first level, and The Spire, an elegant, revolving rooftop restaurant that offers a delicious lunch and dinner menu and a breathtaking view of the Louisville skyline.

The Hyatt has recently completed a major renovation of all guest and meeting rooms, and offers a number of newly constructed meeting rooms

The Hyatt Regency and Commonwealth Convention Center are both ideally located to take advantage of sightseeing, shopping, and dining, and downtown Louisville offers a wealth of things to see and do.

on the first level that will be a welcomed addition to KMA's meeting this year. All business meetings and food functions will be held in the Hyatt.

It is important that you make your room reservations as soon as possible for this year's meeting by calling the Hyatt — 502/587-3454. ***Please be sure and indicate that***

you are attending the KMA meeting in order to receive ***the special convention rate*** of Single — \$68/Double — \$78.

The Commonwealth Convention Center, located at 221 Fourth Avenue, will host KMA's General Sessions, specialty group meetings, and exhibit hall. The main registration desk will be located in the Convention Center. Attendees will enjoy a freshly painted Exhibit Hall and attractive new carpet in the meeting rooms. The Commonwealth Convention Center is one of the most functionally designed facilities of its kind with versatile lighting, computer climate control, and a sophisticated sound system. Complimentary coffee and danish, an exhibitor's lounge, and a snack bar featuring breakfast and lunch items will again be offered in the Exhibit Hall.

Shopping and Sightseeing

The Hyatt Regency and Commonwealth Convention Center

are both ideally located to take advantage of sightseeing, shopping, and dining, and downtown Louisville offers a wealth of things to see and do.

Within a few blocks is the Museum of History and Science with exhibits of modern technology and ancient history along with the IMAX theatre that combines a huge image on a 4-story tall screen with a 27-speaker surround sound system. The

Parking is readily available in downtown Louisville. The Hyatt offers enclosed parking for over 640 cars with additional parking available across the street and connected to the Commonwealth Convention Center by a covered walkway.

IMAX is the only one of its kind in Kentucky, Indiana, and Tennessee. Close to the museum is the Kentucky Art and Craft Gallery featuring works by Kentucky artists. Other downtown attractions include the Kentucky Center for the Arts, Actors Theatre of Louisville, lunch or dinner cruises on the Ohio River aboard the Star of Louisville, the McCauley Theatre, and Louisville Gardens.

Also within walking distance is downtown Louisville's historic district with classic architecture that brings history to life.

Exceptionally fine shopping can be experienced at the Galleria Mall with its 7-story glass enclosed atrium and over 80 retail shops including

major department stores and restaurants. A covered skywalk connects the Galleria to the Hyatt Regency Hotel.

Parking and Transportation

Parking is readily available in downtown Louisville. The Hyatt offers enclosed parking for over 640 cars with additional parking available across the street and connected to the Commonwealth Convention Center by a covered walkway. There are numerous CITYPARK and other public parking garages conveniently located throughout the downtown area.

For a fun and fast way to get around downtown, the Toonerville II Trolley is available **free of charge**. Each of the nine trolleys is a detailed reproduction of streetcars used during the turn of the century that feature mahogany seats and woodwork along with gleaming brass hardware. The historic theme is carried out along the trolley route with authentically styled benches, planters, and street lamps.

Make plans now to attend your 1992 Annual Meeting — September 13-17!



The Hyatt Regency Hotel, site of the 1992 KMA Annual Meeting, is located at 320 West Jefferson Street. There is ample parking within a short distance of the hotel and convention center.



Commonwealth Convention Center, located at 221 Fourth Avenue, will host KMA's General Sessions, specialty group meetings, and exhibit hall. The main registration desk will be located in this Center.

PEOPLE



Diane Maxey



Marsha Harrington

Diane Maxey has been named Manager, Membership Development. She will be responsible for staffing the Membership Committee, Medical Student Section, Resident Physician Section, and for coordinating KMA's practice seminars as well as continuing KMA's recruitment and retention activities.

Diane joined the KMA staff in 1969. Various responsibilities during the years have included assistant managing editor of the *Journal*, special projects involving the Annual Meeting, AMA, Trustee Districts, etc. In May 1984, she assumed full time responsibilities for membership recruitment.

A 1969 graduate of Morehead State University, Diane and her husband, Larry, have two sons.

Marsha Harrington has joined the KMA staff as Controller. She will be responsible for all day-to-day financial operations of the Association.

Ms Harrington earned her degree from Bellarmine College and is a Certified Public Accountant with several years' experience in management, accounting and audits. Prior to pursuing an accounting career, she had worked in banking and finance.

A native of Jeffersonville, Indiana, Marsha and her husband, Steve, now live in Louisville. They have one son, age 16. *KMA*

Kela Lyons, President of the KMA Medical Student Section for 1991-92, was named the 1992 fall semester recipient of the AMA Governmental Relations Internship. Ms Lyons, a junior medical student at the University of Louisville, will work in the AMA Washington Office for four weeks beginning in September 1992.

Active in organized medicine since her freshman year, Ms Lyons previously served as Chapter President of the KMA Section at UL and co-chaired the 1991 Annual Meeting of the MSS and RPS in September.

Ira B. Potter, MD, Prestonsburg, is serving on the U of K Dean's Advisory Board for Rural Health Management and Curriculum Planning.

Joseph P. Bark, MD, Lexington, is author of two books: *Skin Secrets: A Complete Guide to Skin Care for the Entire Family*, McGraw-Hill Book Co, copyright 1987, and *Retin-A and Other Youth Miracles*, Prima Publishing and Communications, copyright 1989. He has been a guest on "Lifestyles" on the Lifetime Network, on the "Home Show with Gary Collins," and Joan Lunden's "Everyday Show" as well as numerous regional and national shows.

UPDATES

UK Physicians Named to "Best Doctors in America" List

The University of Kentucky Medical Center reports that several of their physicians were featured in the fourth edition of "Best Doctors in America," a listing of the nationally recognized physicians in the United States. The U of K list included KMA members

Edward A. Luce, MD, plastic and maxillofacial surgery; **Franklin C. Miller, MD**, obstetrics and gynecology; and **John R. van Nagell, MD**, gynecologic oncology. The book is based on a year-long survey which asked thousands of physicians to rate the clinical abilities of their peers.

U of L Center Specializes in Helping Children with Disabilities

U of L reports that over the past 25 years more than 30,000 children have been cared for at the Child Evaluation Center.

As part of the Department of Pediatrics, the center serves children from birth through age 16. Center professionals study the children's disabilities, as well as their abilities, to determine how they can best get along in the world.

"When we began in 1966, the main focus was on mental retardation," said **Bernard Weisskopf, MD**, director.

Since then the focus has broadened to include learning disabilities, birth defects, attention deficits, and hyperactivity. In recent years, technology has enabled the center to offer testing for genetic disorders and chromosome abnormalities as well as intrauterine diagnosis. A typical comprehensive evaluation includes medical, neurodevelopmental, and psychological examinations.

Specialists in education, speech and language, occupational therapy, physical therapy, and audiology all provide insight into the child's current abilities and future needs. This multidisciplinary approach provides a clear understanding of each child's potential and an appropriate treatment plan, Dr Weisskopf said.

The needs of the family are recognized when dealing with the future of a child with disabilities. The diagnostic team meets with the family to discuss the child's strengths and

weaknesses, test results, and recommendations for treatment, management, and therapy.

Many are referred to the center by pediatricians, family practitioners, health-related agencies, nurses, teachers, and therapists. According to Dr Weisskopf most of the children are from Kentucky and southern Indiana, but they have had referrals from across the United States and Europe. The center also provides outreach programs and developmental evaluations services to western Kentucky.

In addition to working with children with special needs and their families, the center is also a training ground for students, residents, and fellows in developmental pediatrics.

The center has grown significantly during the past 25 years through grants from the Kentucky Cabinet for Human Resources, Division for Maternal and Child Health, and the WHAS Crusade for Children.

Stroke Association Works to Reduce Frequency and Severity of Strokes in Kentucky

KMA members **Roy Meckler, MD**, Louisville; **Dan A. Martin, MD**, Madisonville; and **Charles Dietzen, MD**, Ashland, are among 24 people from all parts of Kentucky to serve on the Stroke Association of Kentucky board.

The Stroke Association is a non-profit public service group which was organized in 1991 with assistance from experts at the University of Kentucky's Sanders-Brown Center on Aging stroke program. Sanders-Brown has been designated a Commonwealth Center of Excellence on Stroke with a mission to address the serious problem of stroke in Kentucky.

Former Governor Martha Lane Collins chairs the board and is a spokesperson for the stroke

association. A list of stroke support groups, education programs, and other resources for patients and families is available by writing the Stroke Association of Kentucky at Box 4415, Lexington, KY 40544.

Recruitment Begins in Rural Areas

Under the direction of **Robert Goodin, MD**, Louisville, Chairman of the KMA Physician Manpower Committee, visitations are being scheduled to rural county high schools around Kentucky to promote medicine as a profession to high school students.

This effort is aimed at reducing the physician maldistribution problem that Kentucky faces in rural and critical counties. The goal is to have a practicing physician and a medical school student from rural areas make presentations at local high schools to encourage more students to consider a medical career.

If you are interested in making a presentation at your local high school, contact KMA. Plans are to have this program in full operation by Fall 1992.

AMA Announces Service for Physicians and Practices Seeking Short-term, Locum Tenens Opportunities

The AMA offers a service for physicians looking for short-term positions and for practices recruiting temporary replacements. AMA's Locum Tenens Service provides recruiters and physicians with the widest possible exposure through listing locum tenens positions in AMA's *Opportunity Placement Register* and through presenting abbreviated curricula vitae of physicians in AMA's *Physician Placement Register*. Complete physician curricula vitae can be ordered through the Service by practices seeking locum tenens physicians. Physicians can also

request profiles of practices offering locum tenens positions.

For more information about the AMA's Locum Tenens Service, please contact AMA's Physicians Career Resource, American Medical Association, PO Box 10012, Chicago, IL 60610, or call 1-800-955-3565.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Barren

Melissa B. Dennison, MD — PD
801 Steeplechase, Glasgow 42141
1984, U of Louisville

Boyle

Anthony C. Enlow, MD — FP
1551 Lannock Dr, Danville 40422
1984, U of Kentucky

Fayette

Leland J. Irwin, MD — EM
1740 S Limestone, Lexington 40503
1979, U of Florida
Andrew D. Ruthberg, MD — RHU
1221 S Broadway, Lexington 40504
1977, Brown U

Hardin

David T. Baumann, MD — OTO
1429 4th Ave #A, Fort Knox 40121
1968, U of Oregon

Jefferson

Thomas R. Baeker, MD — IM
250 E Liberty, #802, Louisville 40202
1980, U of Missouri

John R. Dimar, MD — ORS
210 E Gray #900, Louisville 40202
1981, Wright State
David L. Doering, MD — OBG
Brown Cancer Ctr, Louisville 40201
1980, Medical Col of Alabama
Eugene C. Dorf, MD — OBG
224 E Broadway #200, Louisville 40202

1972, Baylor Col of Medicine
Ian J. Goldberg, DO — C
4402 Churchman #401, Louisville, 40215

1985, New York Col of Osteopathic Medicine

Tonya Robinson, MD — PD
601 S Floyd #804, Louisville 40202
1985, Indiana U

Lori L. Warren, MD — OBG
4003 Kresge Way #229, Louisville 40207
1987, U of Kentucky

McCracken

David T. Gilliam, MD — P
PO Box 1100, Paducah 42002
1974, U of Louisville

Northern Kentucky

Daniel G. Fagel, MD — GE
196 Barnwood Dr, Edgewood 41017
1985, U of Cincinnati

New In-Training

Fayette

Nathan W. Baker, MD — OBG
William G. Simpson, MD — IM

Jefferson

Bashar S. Al-Assaad, MD — IM
Randall D. Borland, MD — PMR
Marissa A. Cornett, MD — R
Michael L. Delk, MD — AN
Karl F. Heinss, MD — IM
Thomas C. Jackson, MD — FP
Stacey E. Merritt, MD — EM

Jeffrey S. Neal, MD — RHU
Vu T. Nguyen, MD — P
Mureena A. Turnquest, MD — OBG
Albert L. Walsh, MD — IM

St. Elizabeth's

Brent E. Bunnell, DO — FP

DEATHS

Wanless R. Mann, MD Campbellsville 1923-1992

Wanless R. Mann, MD, a general practitioner, died May 4, 1992. Dr Mann graduated from the University of Louisville School of Medicine in 1953 and was an active member of KMA.

E. Kenneth Frasher, MD Louisville 1926-1992

E. Kenneth Frasher, MD, a family practitioner, died May 16, 1992. A 1955 graduate of the University of Louisville School of Medicine, Dr Frasher was an inactive member of KMA.

Matthew C. Darnell, MD Lexington 1913-1992

Matthew C. Darnell, MD, an internist, died May 17, 1992. Dr Darnell was one of the founders of Hospice of the Bluegrass and a member of its board of directors from 1977 to 1981. He was active in the Fayette County Medical Society and served as president in 1960. A 1943 graduate of Boston University School of Medicine, Dr Darnell was a life member of KMA.

Make Your Reservations Now

It is important that you begin to make your room reservations as soon as possible for the KMA Annual Meeting, September 14-17. The Hyatt Regency Louisville will be the Headquarters Hotel (Phone 502/587-3434). In making your reservations, remember the first House of Delegates meeting will be Monday, September 14. Be sure and identify yourself as a KMA meeting attendee to receive the special convention rate — Single — \$68/Double — \$78.

Medical Office And Clinic Staff Claims Prevention Program

Kentucky Medical Insurance Company will offer a special claims prevention workshop for medical office and clinic staff during the KMA Annual Meeting. A similar workshop, based on the workbook entitled *Risk Prevention Skills for Medical Office and Clinic Staff*, was presented to over 1500 medical office/clinic staff members in 1991. Over 90% of those participants evaluated the overall program as above average to excellent. The 1992 offering will be based upon the same proven concepts the workbook outlines. However, the workshop has been redesigned to include not only the popular hypothetical situation discussion, but additional information as well.

Participants will be mailed a self-study workbook and accompanying answer sheet which should be completed before the workshop. The answer sheets will be collected at the workshop, and each participant will be mailed an individual score report.

The cost, which includes the workbook, scoring service, and workshop, is \$25 per office/clinic staff member employed by physicians insured by Kentucky Medical. For office/clinic staff whose physician employer is not insured by Kentucky Medical, the cost is \$35 per person.

The workshop is scheduled from 9:00 to 11:00 AM on Wednesday, September 16, 1992, at the Hyatt Regency Hotel, Louisville. In order to register, please call Kentucky Medical Insurance Company either toll free at 800/467-1858, or in Louisville, 338-5771. Prompt registration is encouraged.

RATES AND DATA

All orders for classified advertising must be placed in writing and will be subject to approval by the Editorial Board. The right is reserved to decline or withdraw advertisements at the publisher's discretion.

Deadline: First day of month prior to month of publication.

Word count: Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

Rates to KMA members: \$10 per insertion up to 50 words, 25¢ each additional word. To non-members; \$30 per insertion up to 50 words, 25¢ each additional word.

Send advance payment with order to: The Journal of KMA, 301 N Hurstbourne Pky, Ste 200, Louisville, KY 40222.

PHYSICIAN — Rewarding opportunity for a BE/BC Primary Care/Emergency Medicine Physician. Hassle-free work in an ambulatory care setting, no after-hours call. Industrial/primary/urgent care practice. Excellent compensation. Send resume to Urgent Treatment Center, 3174 Custer Drive, Lexington, KY 40517, or call 606/273-8882.

PHYSICIAN — Challenging/exciting opportunity for an occupational medicine physician. Hassle-free work in a walk-in center. Work with employers and skilled management team. Excellent compensation. Send resume to UTC, 3174 Custer Drive, Lexington, KY 40517 or call 606/273-8882.

INTERNISTS WANTED — We need one or two internists to join us in our active private Suburban practice. No HMO attachments. Computerized office located in suburban Louisville. Lab and x-ray facilities equipped and staffed. Arrangements flexible. Olash Medical Associates, Suburban Medical Plaza, 4001 Dutchmans Lane, Suite 4F, Louisville, KY 40207, 502/897-0146.

NEW BOOK — "Louisville's Early Medicine Bottles." Descriptions and drawings including 83 Pontils, 58 Bitters, 37 Sarsaparillas and 24 Cure bottles all from Louisville, Ky. Over 600 bottles listed. Ads, trade cards, stories of Louisville's medicines of the 1800's. Gene Blasi, R.Ph., 5801 River Knolls Dr, Louisville, KY 40222. (\$13 by mail).

JOHN J. GUARNASCHELLI, M.D.

is pleased to announce that

DAVID A. PETRUSKA, M.D.

will join him in the practice of

NEUROLOGICAL SURGERY

effective July 1, 1992

at

225 Abraham Flexner Way Suite 505

Louisville, Kentucky 40202

(502) 584-4121

Fax (502) 584-6626

What is your specialty?

Doctor of Medicine (MD)
Doctor of Osteopathy (DO)



Whatever your medical specialty, you can count on the **Kentucky Air Guard** to put your skills to work in a way that will enrich your life and career.

To find out about:

Benefits
Eligibility
Participation requirements
Military grade
Military pay
Training
Assignments
Retirement

Contact: **SMSgt. Todd Beasley,**
Kentucky Air National Guard
(502) 364-9424 (call collect)

A New Prescription for Kentucky's Indigent Health Care

Effective July 1, 1992, six members of the Johnson & Johnson family of companies joined Pfizer/Roerig Pharmaceuticals and the G. D. Searle Company in providing their prescription drugs free of charge to certified eligible Kentucky Physicians Care patients.

The six new members joining the Kentucky Pharmacy Providers program are: Iolab Corporation; Janssen Pharmaceutica, Inc.; McNeil Pharmaceutical; McNeil Consumer Products Company; Ortho Biotech, Inc.; and Ortho Pharmaceutical Corporation. Their products range from oral contraceptives to analgesics to allergy medications and antibacterials.

In extending this access to prescription drugs, Pfizer/Roerig, Searle, Iolab, Janssen, McNeil, and Ortho are making their products available at **no cost** and participating pharmacists are dispensing them **without charge** to eligible ambulatory patients. ***Only prescriptions written for products from the above named companies for KPC eligible patients by KPC participating physicians will be filled through the Kentucky Pharmacy Providers program.***

If you have questions, or for those physicians not currently participating in KPC who wish to participate, please contact the KPC referral office — **1-800-633-8100** — or the KMA Headquarters Office — **(502) 426-6200**.

**PLEASE REFER TO THE FOLLOWING PAGES
FOR A LIST OF AVAILABLE
PFIZER/ROERIG, SEARLE, AND JOHNSON & JOHNSON PRODUCTS
AND A LIST OF PARTICIPATING PHARMACIES**

PHARMACEUTICALS AVAILABLE TO KENTUCKY PHYSICIANS CARE

These Johnson & Johnson pharmaceuticals may be prescribed and dispensed under the program:

Iolab Corporation

Argyrol® S.S. (mild silver protein)
Atropisol® Ophthalmic Solution (atropine sulfate)
Catarase® (chymotrypsin)
Dexacidin® Ophthalmic Suspension and Ointment (dexamethasone, neomycin and polymyxin B. sulfates)
Dexamethasone Sodium Phosphate Ophthalmic Solution 0.1%
Dexamethasone Sodium Phosphate 4 mg/ml (for injection)
Epinephrine
E-PILO® Ophthalmic Solution (epinephrine bitartrate-pilocarpine HCl)
Eserine Sulfate Sterile Ophthalmic Solution
Fluorescein Sodium
Fluor-Op® Ophthalmic Suspension (fluorometholone .1%)
Funduscein® -10, -25 Injection (fluorescein sodium)
Gentacidin® Solution and Ointment (gentamicin sulfate)
Gentamicin 40 mg/ml, 80 mg/2 ml (for injection)
Glucose-40 Sterile Ophthalmic Ointment
Homatropine Hydrobromide
Inflamase® Forte Ophthalmic Solution (prednisolone sodium phosphate)

Inflamase® Mild Ophthalmic Solution (prednisolone sodium phosphate)
Iocare® Balanced Salt Solution
Miochol® Intraocular & System Pak (acetylcholine chloride)
Neomycin, Polymyxin B sulfates, and Hydrocortisone Ophthalmic Suspension
Neomycin, Polymyxin B sulfates, and Gramidicin Ophthalmic Solution
Neomycin Sulfate/Dexamethasone Sodium Phosphate Ophthalmic Solution
Phenylephrine HCl 10%/2.5%
Pilocar® Ophthalmic Solution (pilocarpine HCl)
Sulf-10® Ophthalmic Solution (sodium sulfacetamide)
Tetracaine HCl
Vasocidin® Ophthalmic Solution (sulfacetamide sodium-prednisolone sodium phosphate) & Ointment (sulfacetamide sodium-prednisolone acetate)
Vasocon-A Ophthalmic Solution (naphazoline HCl-antazoline phosphate)
Vasocon Regular Ophthalmic Solution (naphazoline HCl 0.1%)
Vasosulf® Ophthalmic Solution (sulfacetamide sodium-phenylephrine HCl)

Janssen Pharmaceutica, Inc.

*Duragesic® Transdermal system (fentanyl)
Ergamisol® Tablets (levamisole HCl)
Hismanal® Tablets (astemizole)
Imodium® Capsules (loperamide HCl)

Nizoral® Cream (ketoconazole)
Nizoral® Shampoo (ketoconazole)
Nizoral® Tablets (ketoconazole)
Vermox® Tablets (mebendazole)

McNeil Consumer Products Company

Chemet® Capsules (succimer)

Pediaprofen™ Suspension (ibuprofen)

McNeil Pharmaceutical

Floxin® Tablets (ofloxacin)
Haldol® Tablets and Concentrate (haloperidol)
Haldol® Decanoate Injection (haloperidol)
Pancrease® Capsules (pancrelipase)
Pancrease® MT Capsules (pancrelipase)
Paraflex® Caplets (chlorzoxazone)

Parafon Forte® DSC Caplets (chlorzoxazone)
Tolectin® Capsules and Tablets (tolmetin sodium)
Tylenol® with Codeine Tablets and Elixir (acetaminophen and codeine phosphate)
*Tylox® Capsules (oxycodone hydrochloride and acetaminophen capsules USP)
Vascor® Tablets (bepridil HCl)

Ortho Biotech

Procrit® Injection (epoetin Alfa)

Ortho Pharmaceutical Corporation

Aci-Jel® Therapeutic Vaginal Jelly
Floxin® Tablets (ofloxacin)
Micronor® Tablets (norethindrone)
Modicon® Tablets (norethindrone/ethinyl estradiol)
Ortho® Dienestrol cream (dienestrol)
Ortho-Novum® Tablets (norethindrone/mestranol) or (norethindrone/ethinyl estradiol)
Protostat® Tablets (metronidazole)
Sultrin® Triple Sulfa Cream and Vaginal Tablets (sulfathiazole/sulfacetamide/sulfabenzamide)

Terazol® Cream and Vaginal Suppositories (terconazole)
Erycette® Topical Solution (erythromycin)
Grifulvin V® Tablets/suspension (griseofulvin microsize)
Meclan® Cream (meclocycline sulfasalicylate)
Monistat Derm® Cream (miconazole nitrate)
Persa-Gel® & Persa-Gel® W (benzoyl peroxide)
Retin-A® Cream/Gel/Liquid (tretinoin)
Spectazole® Cream (econazole nitrate)

*Duragesic® and Tylox® (CII controlled substances) will be replaced with other products.

PHARMACEUTICALS AVAILABLE TO KENTUCKY PHYSICIANS CARE

These Pfizer/Roerig & Searle pharmaceuticals may be prescribed and dispensed under the program:

Pfizer Labs

Antiminth® (Pyrantel pamoate) OTC
Cortril® Topical Ointment 1% (Hydrocortisone) Rx
Diabinese® Tablets (Chlorpropamide) Rx
Diabinese® Tablets Unit-Dose Pak (Chlorpropamide) Rx
Feldene® Capsules (Piroxicam) Rx
Feldene® Capsules Unit-Dose Pak (Piroxicam) Rx
Minipress® Capsules (Prazosin HCl) Rx
Minipress® Capsules Unit-Dose Pak (Prazosin) Rx
Minizide® 1 Capsules (1 mg. Prazosin and 0.5 mg. Polythiazide) Rx
Minizide® 2 Capsules (2 mg. Prazosin and 0.5 mg. Polythiazide) Rx
Minizide® 5 Capsules (5 mg. Prazosin and 0.5 mg. Polythiazide) Rx
Moderil® Tablets (Rescinnamine) Rx
Procardia® Capsules (Nifedipine) Rx
Procardia® Capsules Unit-Dose Pak (Nifedipine) Rx
Procardia XL® (Nifedipine) Extended Release Tablets Rx
Procardia XL® (Nifedipine) Extended Release Tablets Unit-Dose Pak Rx

Renese® Tablets (Polythiazide) Rx
Renese®-R Tablets (2 mg. Polythiazide and 0.25 mg. Reserpine) Rx
Sustaire® (Theophylline anhydrous) Rx
Terramycin® Capsules (Oxytetracycline HCl) Rx
Vansil® Capsules (Oxamniquine) Rx
Vibra-Tabs® (Doxycycline hyclate) Rx
Vibra-Tabs® Unit-Dose Pak (Doxycycline hyclate) Rx
Vibramycin® Calcium Syrup (Doxycycline calcium oral suspension) Rx
Vibramycin® Hyclate Capsules (Doxycycline hyclate) Rx
Vibramycin® Hyclate Capsules Unit-Dose Pak (Doxycycline hyclate) Rx
Vibramycin® Monohydrate for Oral Suspension (Doxycycline monohydrate) Rx
Vistaril® Capsules (Hydroxyzine pamoate) Rx
Vistaril® Capsules Unit-Dose Pak (Hydroxyzine pamoate) Rx
Vistaril® Oral Suspension (Hydroxyzine pamoate) Rx
Zithromax® Capsules (Azithromycin)

Roerig

Antivert® (Meclizine HCl) Rx
Antivert® Tablets Unit-Dose Pak (Meclizine HCl) Rx
Atarax® (Hydroxyzine HCl) Rx
Atarax® Tablets Unit-Dose Pak (Hydroxyzine HCl) Rx
Bonine® Chewable Tablets (Meclizine HCl) OTC
Cefobid® (Cefoperazone sodium) Rx
Diflucan® (Fluconazole) Oral and Parenteral Antifungal Rx
Diflucan® (Fluconazole) Unit-Dose Pak Oral and Parenteral Antifungal Rx
Emete-con® IM/IV (Benzquinamide HCl) Rx
Geocillin® (Carbenicillin indanyl sodium) equivalent to 382 mg. carbenicillin Rx
Geopen IM/IV (Carbenicillin disodium) Rx
Glucotrol® Tablets (Glipizide) Rx
Glucotrol® Tablets Unit-Dose Pak (Glipizide) Rx
Heptuna® Plus Capsules (Iron plus vitamins and minerals) Rx
Hydrocortisone Powder (Hydrocortisone USP micronized) Rx
Isoject® Permapen® (Penicillin G benzathine) Aqueous Suspension Rx
Marax® (Hydroxyzine HCl [ATARAX®]-Theophylline-ephedrine sulfate) Rx
Navane® Capsules (Thiothixene) Rx
Navane® Capsules Unit-Dose Pak (Thiothixene) Rx
Navane® Concentrate (Thiothixene HCl) Rx
Navane® Intramuscular (Thiothixene HCl) Rx
Pfizerpen® for Injection (Penicillin G potassium) Buffered Rx

Pfizerpen®-AS (Penicillin G procaine) Aqueous Suspension Rx
Polymyxin B Sulfate Sterile Rx
Sinequan® Capsules (Doxepin HCl) Rx
Sinequan® Capsules Unit-Dose Pak (Doxepin HCl) Rx
Sinequan® Capsules Unit of Use Pak (Doxepin HCl) Rx
Sinequan® Oral Concentrate (Doxepin HCl) Rx
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Spectrobid® Tablets (Bacampicillin HCl) Rx
Streptomycin Sulfate Rx
Tao® Capsules (Troleandomycin) Rx
Terra-Cortril® Ophthalmic Suspension (Oxytetracycline HCl and hydrocortisone acetate) Rx
Terramycin® Intramuscular Solution (Oxytetracycline) Rx
Terramycin® Ophthalmic Ointment with Polymyxin B Sulfate (Oxytetracycline HCl with polymyxin B sulfate) Rx
Terramycin® Vaginal Tablets with Polymyxin B Sulfate (Oxytetracycline HCl with polymyxin B sulfate) Rx
Unasyn® (Ampicillin sodium/sulbactam sodium) Rx
Urobiotic® 250 (250 mg. Oxytetracycline HCl 250 mg. sulfamethizole 50 mg. phenazopyridine HCl) Rx
Vibramycin® Intravenous (Doxycycline hyclate for injection) Rx
Vistaril® Intramuscular Solution (Hydroxyzine HCl) Rx
Vistaril® Intramuscular Solution Unit-Dose Vials (Hydroxyzine HCl) Rx

Roerig & Pratt Division

Zolof® Tablets (Sertraline)

Searle

Aldactazide® tablets (spironolactone with hydrochlorothiazide)
Aldactone® tablets (spironolactone)
Calan® SR caplets (verapamil HCl)
Calan® caplets (verapamil HCl)
Cytotec® tablets (misoprostol)

Kerlone® tablets (betaxolol HCl)
Nitrodisc® discs (nitroglycerin)
Norpace® capsules (disopyramide phosphate)
Norpace® CR capsules (disopyramide phosphate)

PARTICIPATING PHARMACIES KPC PHARMACY PROVIDER PROGRAM

<p>Adair DBA Columbia Pharmacy Madison Square Drugs & Chymist</p> <p>Allen Carpenter Dent Drugs Stovall Prescription Shop Williams Pharmacy</p> <p>Anderson The Medicine Shoppe Reliable Drugs</p> <p>Barren Ely Drugs, Inc. Glasgow Prescription Center Tawne & Country Drugs</p> <p>Bell City & County Drug Farris Drugs Jeff's Pharmacy Kroger Company Pineville Hos. Out-Pt Pharmacy SuperX Drugs Tatal B. Care Pharmacy</p> <p>Boone Boone County Drugs Burlington Pharmacy SuperX Drugs Turfway Pharmacy</p> <p>Bourbon Glen's Drugs Harne's Ardrey Drug The Medicine Shoppe</p> <p>Bayd McMeans Pharmacy Reliable Drugs SuperX Drugs</p> <p>Bayle Grider Pharmacy Leake Pharmacy SuperX Drugs Taylor Drug</p> <p>Bracken Dean's Pharmacy</p> <p>Breathitt Jackson Prescription Ctr Reliable Drugs</p> <p>Breckinridge Save-Rite Drugs Tawne & Country Pharmacy</p> <p>Bullitt Taylor Drugs</p> <p>Caldwell Payless Discount Pharmacy The Pharmacy Corner Enterprise</p> <p>Callaway Clinic Pharmacy Holland Drugs Reliable Drugs Safe-T Discount Pharmacy Walter's Pharmacy</p>	<p>Campbell Alexandria Drugs Martin's Pharmacy Newport Drug Center SuperX Drugs</p> <p>Carroll Parklane Pharmacy Webster Drugs</p> <p>Carter Horton Brother & Brown Rase Pharmacy</p> <p>Christian Express Pharmacy Horn Prescription Shop Jennie Stuart Medical Center Reliable Drugs Save More Drug The Medicine Shoppe</p> <p>Clark Carner Drug Store Day Drugs Reliable Drugs SuperX Drugs</p> <p>Clay Family Drug Center H & N Drug Medi Center Drugs</p> <p>Crittenden Glenn's Apothecary</p> <p>Cumberland Smith Pharmacy</p> <p>Daviess Danhauer Drug Company Emery Centre Pharmacy Greene's Pharmacy Harrell's Drug Store Mayfair Pharmacy Medical Plaza Pharmacy Medicine Shoppe Nation's Medicines Reliable Drugs Taylor Drug #21 Wal-Mart Pharmacy</p> <p>Edmanson Prescription Shop</p> <p>Fayette Hi-Acres Pharmacy Hubbard & Curry Pharmacy Hutchinson Drug All Kroger Pharmacies Professional Arts Apothecary Randall's Pharmacy Taylor Drugs The Medicine Shoppe Warehouse Drugs Woodhill Pharmacy</p> <p>Fleming Plaza Pharmacy</p>	<p>Flayd Archer Clinic Pharmacy Betsy Layne Pharmacy Mud Creek Clinic Pharmacy Our Lady Of The Way Hospital</p> <p>Franklin East Side Pharmacy Fitzgerald Drugs Kroger Pharmacy Medicine Shoppe Reliable Drugs Taylor Drugs The Prescription Center</p> <p>Fulton City Super Drug Evans Drug Company Rumfelt Drug SuperX Drugs</p> <p>Garrard Sutton Pharmacy</p> <p>Grant Grant County Drugs</p> <p>Graves Stanes Drugs SuperX Drugs Wilson Rexall Drugs</p> <p>Graysan Clarkson Drug Store Reliable Drugs</p> <p>Green Model Drug Store</p> <p>Greenup Reliable Drugs Scott Drugs Stultz Pharmacy</p> <p>Hardin Jeff's Prescription Shop Kroger Company Shawers & Hays Drugs SuperX Drugs Taylor Drugs</p> <p>Harlan Lynch Med. Services Pharmacy SuperX Drugs</p> <p>Harrison Eastside Pharmacy Of Cynthia Lee Drugs</p> <p>Hart Branstetter Pharmacy Clarks Mallory Drugs</p> <p>Hendersan Dunaway's Imperial Pharmacy Reliable Drugs T & T Drugs</p> <p>Henry Cook's Pharmacy</p>	<p>Hopkins Earlington Pharmacy Family Drugs Madisonville Pharmacy Nation's Medicines Professional Drugs #2 Reliable Drugs SuperX Drugs</p> <p>Jackson Annville Pharmacy Clinic Pharmacy</p> <p>Jefferson Alliant Health System Pharmacy Art Jacob Prescription Shoppe Calanial Drugs Cox's Pharmacy DBA Hametek Pharmacy Harding Pharmacy Haldaway Drugs Hume Pharmacy Koby Drug Company All Kroger Pharmacies Oak Drug Company, #1 Rauben's Pharmacy St. Denis All Care All SuperX Drugs All Taylor Drugs Union Prescription Center Wal-Mart Pharmacies Warehouse Drugs</p> <p>Jessamine Drug Mart Medicine Shoppe Taylor Drugs</p> <p>Johnson Bi-Rite Pharmacy Reliable Drugs</p> <p>Kenton Blank's Pharmacy Boeckley Drugs Cherokee Drug Shoppe Crestville Drugs Farrell Pharmacy Fart Mitchell Drug Shoppe Fart Mitchell Pharmacy Ludlow Drugs Medical Village Pharmacy Marwessel Drugs Nie's Independence Pharmacy Save Discount Drugs All SuperX Drugs</p> <p>Knox Knox Professional Pharmacy Sav-Rite Pharmacy</p> <p>Laurel Family Drugs Kelley's Medical Arts Pharmacy Laurel Heights Nursing Home Landon City Drug Co. Landon-Carbin Pharmacy SuperX Drugs</p> <p>Lee Stufflebean Pharmacy Three Farks Apothecary</p>
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PARTICIPATING PHARMACIES KPC PHARMACY PROVIDER PROGRAM

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Shopwise Pharmacy

Lincoln

Caleman's Drug Store
Rishie Drugs

Livingston

Glenn's Prescription Center

Logan

Gower Drug Store
Riley-White Drugs
Wal-Mart Pharmacy

Madison

Berea Hospital Out-Patient
Kroger Company
SuperX Drugs

Magoffin

Clinic Pharmacy

Marian

Hagan-O'Daniel Pharmacy
Pat's Pharmacy
Reliable Drugs
Southall Pharmacy

Marshall

Benton Discount Pharmacy
Draffenville Pharmacy
J & R Pharmacy
Nelson ValuRite Pharmacy
Pay-N-Save Discount Drugs

Mason

Medical Arts Pharmacy
Reliable Drugs
Tancray Martor & Pestle
Kentucky Med KPC Program sandy
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McCracken

Davis Drugs
Katterjohn Drug Store
Kroger
SuperX Drugs
The Medicine Shoppe

McCreary

Burgess Drug Store
Daugherty Drugs

Meade

Riverview Pharmacy

Mercer

Kroger Company
SuperX Drugs

Metcalfe

Metcalfe Drugs
Nunn Drugs

Mantgomery

Calico & Whitt Drug
Emil W. Baker, Pharmacist
Ross Drugs
SuperX Drugs

Muhlenberg

Beechmont Pharmacy
Clinic Pharmacy
Reliable Drugs

Nelson

Reliable Drugs

Nicholas

Carlisle Drug

Ohio

L. L. Bane Pharmacy
Reliable Drugs
Rice Drug Store

Oldham

Taylor Drugs

Owsley

Owsley Prescription Center

Pendleton

Moreland Drug

Perry

L. B. Clinic Pharmacy
Reliable Drugs
SuperX Drugs
Vicca Pharmacy

Pike

Medical Pharmacy
Nichols Apothecary
SuperX Drugs

Pulaski

Brawn's Bogle Street Pharmacy
Kroger Company
Reliable Drugs
Somerset Pharmacy
SuperX Drugs
The Medicine Shoppe
Tibbals Drug Store
Wal-Mart Pharmacy

Rockcastle

Mt. Vernon Drive-Thru
Youngs Pharmacy

Rawan

Cave Run Pharmacy
Reliable Drugs

Russell

Daugherty Pharmacy
Happer Drug

Scott

Doctor's Park Pharmacy
Fitch Drug Store
Kroger Company
Reliable Drugs

Shelby

Reliable Drugs
Smith-McKenney

Simpson

Arnald Drug Company
Prescription Shop
R. H. Moore Drug Company
Reliable Drugs
Shugart & Willis

Spencer

W. T. Framan Drug Company

Taylor

Central Drug Center
Kroger Company
SuperX Drugs
The Medicine Shoppe

Todd

Weathers Drugs

Trigg

Save On Drugs

Union

Clements Drug
Carner Drug Store
Professional Drugs #1
Reliable Drugs
Sturgis Pharmacy

Warren

Ashley Circle Pharmacy
C. D. S. #10 Drug
Clinic Pharmacy
Medicine Shoppe
Northgate Pharmacy
Reliable Drugs
SuperX Drugs
Taylor Drugs
Williams Drug Company

Washington

County Drug

Wayne

Daffran Drug
F & H Drug
Plaza Drugs

Webster

Providence Pharmacy
Thrifty Pharmacy, Inc.

Whitley

Cattangim Drug Company
Doctors Park Apothecary

Walfe

Campton Discount Drugs

Woodford

Carner Drug of Versailles
Midway Drug
SuperX Drugs
Taylor Drugs

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**Please notify us at least
two months in advance.**

Send new address to:

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 301 N Hurstbourne Pkwy, Suite 200
 Louisville, KY 40222-8512**

New chiefs of staff, medical staff committee chairpersons, clinical department heads and other medical staff leaders

You need the skills of
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Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully

monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecostasia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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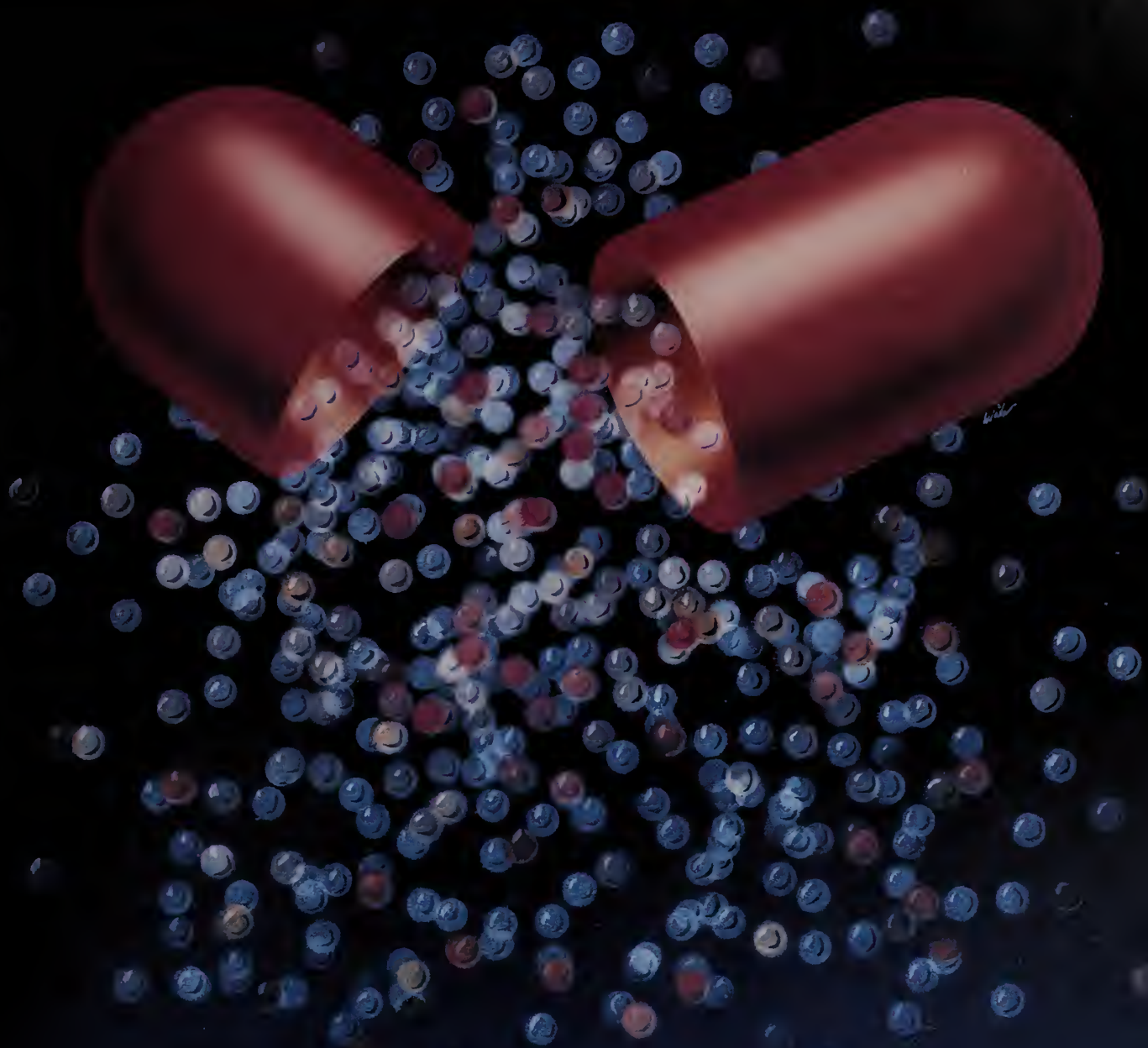
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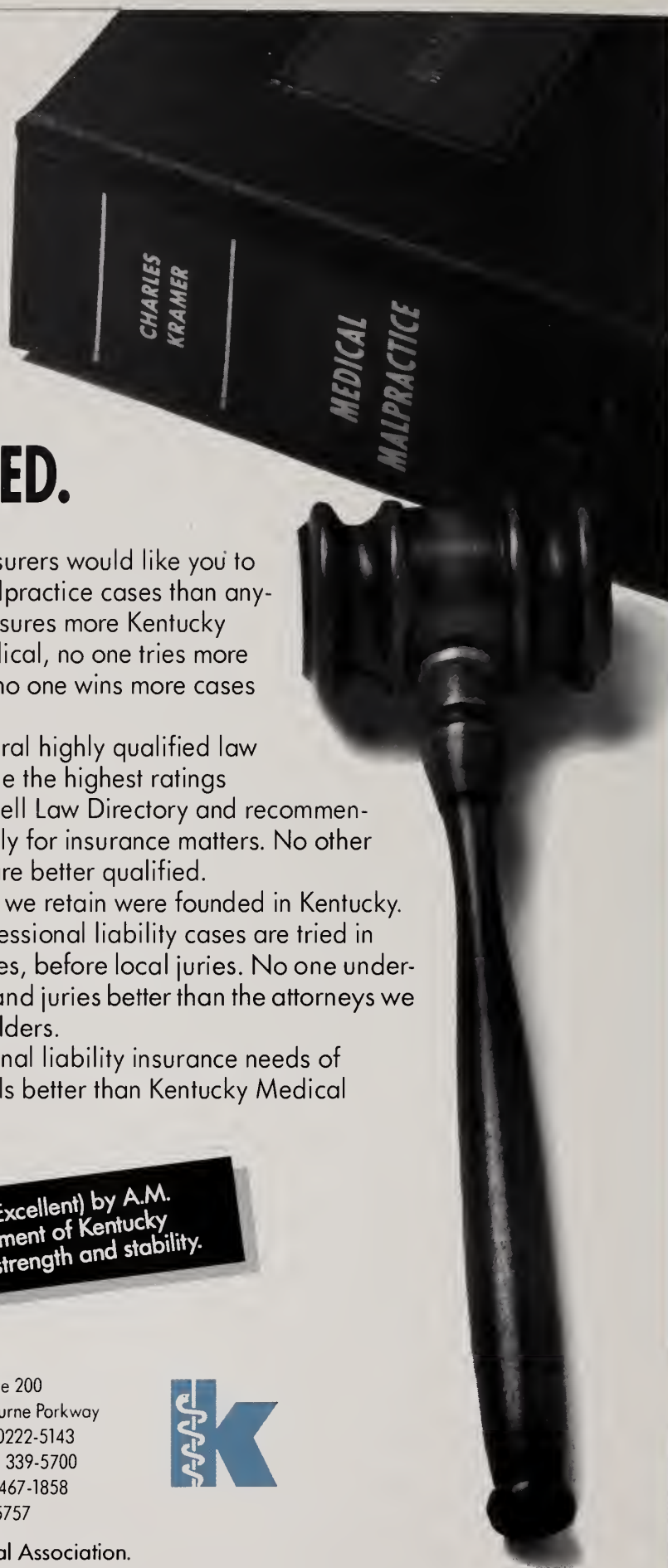
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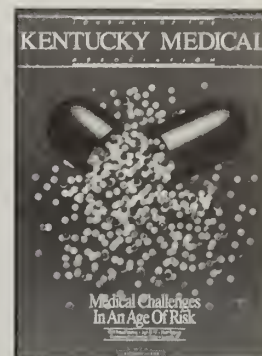


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AUGUST 1992

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COVER: "Medical Challenges in an Age of Risk" is the theme of this year's KMA Annual Meeting, to be held September 13-17 in Louisville. For more information, see the Annual Meeting Section in this issue, beginning on page 389. Cover design by Lee Wade.

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Inevitable Change

Health care is the most compelling issue on the domestic agenda today. Discussions concerning this issue become even more intense as cost and access to health care affect ever-increasing numbers of our population.

Statistically, we — that is, our government, our insurance companies, and our patients, spend more than \$600 billion per year on health care. Predictions are that in 1992 one of every \$7 or 14% of our Gross National Product will be spent on health care. Despite this we still had, in 1991, 35 million individuals in this country living without health insurance. One of our major concerns is that all individuals will be able to obtain medical services when they are needed.

This problem continues to move increasingly to the forefront and, as it does, so does the national policy debate in our nation's Capitol, our national media, our state Capitols, and in small towns and various workplaces across the country. Our legislative leaders, health experts, and special interest groups review many new proposals or modifications of old proposals on a daily basis. Unfortunately, there has been no consensus and no easy answers have been forthcoming.

Over the years there has been a tremendous increase in wealth and in the use of wealth to purchase health care. Our country has been the leader in this trend.

Comparing the amount of health care people use per capita in the most advanced countries in the world, you'll see that the United States is at the top of the list. We spend over twice as much per person, that is, \$2,200 compared to \$1,000 or less for other countries.

There are those who feel that our

health care system is not a good system, just an expensive one. Most often they use two sets of statistics to prove their point.

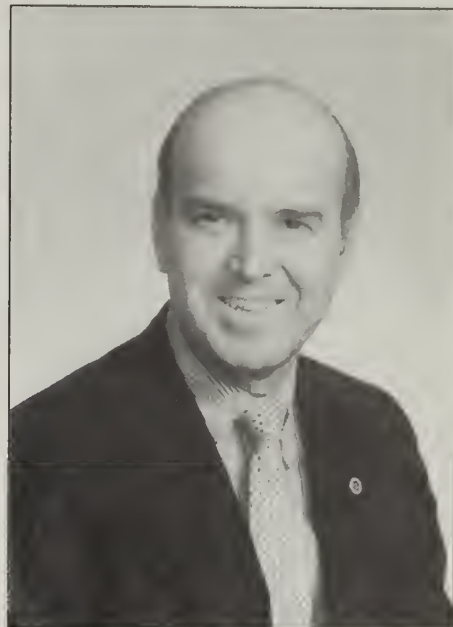
Infant mortality is one set of statistics. From 1900 to 1989 the infant mortality rate has dropped dramatically everywhere — from over 100 deaths per thousand births to under 10. The United States has the worst statistics of all developed countries.

The other statistic is life expectancy at birth, where again we do not look as good as other countries.

Health experts would propose that these differences are more related to societal factors than to the quality of health care. Our neighbor to the north, Canada, looks better in these statistics than we do. Society-wise, however, it has three times fewer AIDS victims and four times fewer homicides per capita. Also, the incidence of drug use is much higher in the United States. Our low ranking in infant mortality is probably more related to diverse reporting systems in other countries and to "crack" babies than it is to the health care system.

While it is true that the United States is in the bottom third of life

"We believe that any change must incorporate those aspects of the present system that have enabled Kentucky medicine to attain an unparalleled level of quality."



expectancy at birth, we are in the middle third for life expectancy when at age 60, and the leader in the world in life expectancy at 80. This is a reflection of the large resources we are putting into the Medicare system. These statistics would indicate that it isn't the quality of our care but where we put our resources that is significant.

Your leadership and staff at KMA have been and are currently involved in developing and refining KMA's health plan. We do this in order to determine the best use of our resources to address the problems of health care access and cost.

The severity of this problem's impact on the people of Kentucky makes change inevitable. We believe that any change must incorporate those aspects of the present system that have enabled Kentucky medicine to attain an unparalleled level of quality. We recognize that to attain these goals we will be expected to make some personal sacrifices — which we are willing to do, but would expect others to sacrifice as well.

S. Randolph Scheen, MD
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Pyogenic Infections of the Spine

Steven D. Glassman, MD; Christopher B. Shields, MD; Julio C. Melo, MD;
John R. Johnson, MD; Rolando M. Puno, MD

From the Department of Orthopaedic Surgery (Drs Glassman, Johnson and Puno); Department of Surgery, Division of Neurosurgery (Dr Shields); Department of Medicine, Section of Infectious Disease (Dr Melo); University of Louisville School of Medicine, and the Kenton D. Leatherman Spine Center, Louisville, Kentucky.

P pyogenic infections of the spine are an increasing cause of morbidity, particularly in immunosuppressed or otherwise predisposed patients. The prototype of spinal infections is a tuberculous vertebral osteomyelitis, first described by Percival Pott in the late 1700s. Commonly known as Pott's disease, the natural history of tuberculous osteomyelitis of the spine has been extensively studied and well documented.^{3,5,7} While the incidence of tuberculous osteomyelitis in the United States has declined over the past 10 years, the incidence of nontuberculous pyogenic osteomyelitis has increased.¹ In this report, two cases of pyogenic osteomyelitis treated at the Kenton D. Leatherman (KDL) Spine Center over the past year are presented. The clinical presentation, natural history, and treatment of pyogenic vertebral osteomyelitis are reviewed.

Case Reports

Case #1 is a 60-year-old white male with insulin dependent diabetes mellitus. He underwent a L4-5 posterior spinal decompression for complaints of leg pain and weakness 6 months prior to his presentation at the KDL Spine Center. Two months after his initial surgery, the patient developed a perirectal fistula which drained persistently. Three months later, a psoas abscess was detected and the patient underwent an open drainage procedure via a left flank approach. When he subsequently developed severe low back pain and leg weakness, the patient was referred to our center for further treatment.

Evaluation by plain x-ray, MRI scan, and myelogram revealed significant destruction of the L3 and L4 vertebral bodies, with collapse in the anterior column of the spine (Fig 1). As a result of his progressive neurologic deficit and deformity, despite antibiotic therapy, the patient underwent a multistage operative intervention. The first procedure consisted of vertebrectomies at L3 and L4, with partial vertebral body resection at L2 and L5. After adequate anterior spinal decompression and debridement, reconstruction was performed using an autologous fibular strut graft from L2 to L5. Following 2 weeks of postoperative antibiotic therapy with intravenous nafcillin sodium, he was

returned to the operating room, where he underwent decompressive laminotomies and foraminotomies at L3-4 and L4-5, and spinal fusion with instrumentation and autologous iliac crest bone graft from L1 to the sacrum.

Postoperatively, the patient was maintained in an oyster shell thoracolumbosacral orthosis (TLSO) and was restricted from sitting for 6 months. He underwent extensive physical therapy. One year postoperatively, he is ambulating independently, is pain free, and is without recurrence of his infection.

Case #2 is a 47-year-old white male who underwent renal transplantation, as the result of hypertensive renal disease, 4 years prior to his presentation to the KDL spine center. Past medical history is also significant for pulmonary tuberculosis, coronary artery disease, peptic ulcer disease with GI bleeding, pancreatitis, cholecystitis, and methicillin resistant staph aureus septicemia. Following his septicemia, the patient developed spinal osteomyelitis with severe back pain and bilateral leg weakness. Failure to respond to conservative therapy was emphasized by an episode of systemic sepsis resulting in hypotension and altered mental status despite ongoing intravenous vancomycin hydrochloride therapy (Fig 2). The patient was taken to the operating room where he underwent anterior debridement of the involved vertebral bodies and reconstruction with an autologous fibular strut graft. Following an additional 2-week course of intravenous vancomycin hydrochloride, he underwent posterior spinal fusion from T11 to L4 with instrumentation and allograft bone.

Postoperatively, the patient was treated in an oyster shell (TLSO) brace. He required a prolonged course of rehabilitation, during which time both his pain and weakness diminished. His postoperative course had been complicated by a recurrent episode of sepsis, characterized by elevated white blood cell count, persistent temperature spikes, and increased back pain. The primary source of this infection was not identified, as the radiologic evaluation, including bone scan, gallium scan, and CT scan, was without evidence of abscess. The patient responded to

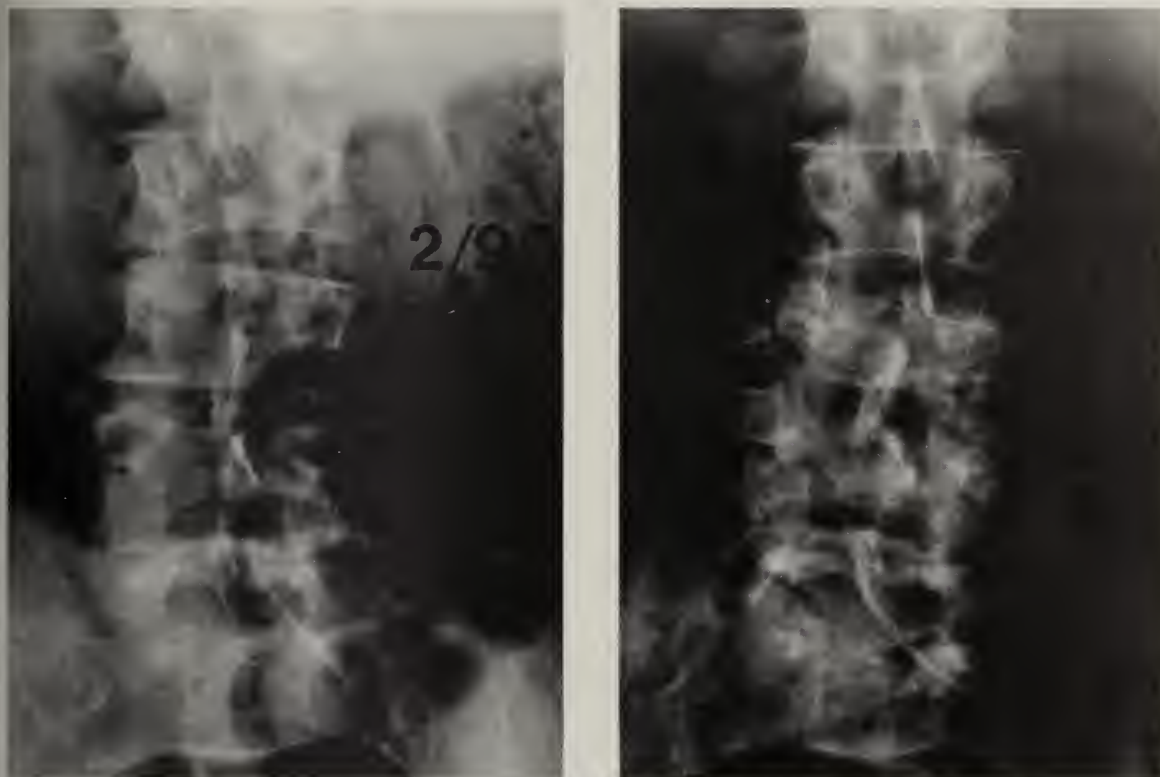


Fig 1 — A and B. AP radiographs demonstrating progression of the spinal deformity during the 6-month period prior to presentation at the KDL Spine Center.

a course of intravenous antibiotic therapy. Eight months postoperatively, the patient complains of mild to moderate back pain, but is ambulating independently, and without a brace. He has had several episodes of low grade temperature elevation and malaise; however, repeated blood and urine cultures remain negative. Serial CT scans show no evidence of recurrent osteomyelitis.

Discussion

Pyogenic vertebral osteomyelitis is a disease process which is often successfully managed by intravenous antibiotic treatment alone. In contrast to tuberculous spinal infections, pyogenic osteomyelitis often results in spontaneous interbody auto-fusion. Occasionally, diagnosis is difficult and the infection may progress despite appropriate antibiotic treatment.

It is important to differentiate pyogenic vertebral osteomyelitis from isolated disc space infection. Spontaneous disc space infection occurs



Fig 2 — MRI study revealing vertebral body destruction at L1 and L2.

Pyogenic Infection of the Spine

most commonly in children, and an offending organism is often difficult to isolate. The necessity for antibiotic treatment in discitis has been questioned, although most authors favor a combination of antibiotic therapy and immobilization.⁸ In pyogenic vertebral osteomyelitis, involvement of the vertebral body itself is significant. The origin of the infection, either in the body or adjacent disc space, may be difficult to determine; however, regardless of the primary site, pyogenic vertebral osteomyelitis tends to become confluent and the infecting organism is more rapidly identified.

As with most infections involving bone, *Staphylococcus aureus* is the most common infecting organism. In pyogenic vertebral osteomyelitis, gram negative rods are also frequent pathogens. The characteristic organisms are indicative of the common sources of infection; genitourinary tract infection or manipulation, and skin infection.^{1,3} *Pseudomonas aeruginosa* has been associated with spine infections in intravenous drug abusers.

The difficulty in making the diagnosis of pyogenic vertebral osteomyelitis is related to the nonspecific nature of the presenting complaints. Although symptoms will progress, they often begin as subacute or chronic complaints. Patients report flu-like symptoms, back pain, and low-grade fever. Significant past medical history may include diabetes mellitus, renal disease, genitourinary manipulation, alcohol use, or prior neoplasm. Patients may be immunosuppressed secondary to disease or medications such as anti-tumor agents or corticosteroids.

Physical exam and laboratory findings may be subtle in the early stages of pyogenic vertebral osteomyelitis. Examination may reveal nonspecific findings such as paraspinal muscle spasm, tenderness to palpation, or pain on range of motion testing in the lumbar or thoracic spine. Neurologic deficits are unusual, and may be suggestive of epidural abscess. In a review of 61 patients with vertebral osteomyelitis, Eismont and Bohlman noted that factors including diabetes mellitus, rheumatoid arthritis, advanced age, or a high level of cord compression are associated with an increased likelihood of paralysis.⁴ Laboratory findings which may be useful in pyogenic vertebral osteomyelitis include elevated white blood cell count with a left shift on differential, elevated erythrocyte sedimentation rate (ESR), and positive blood or urine cultures. Additional evaluation for potential sources of infection are per-

formed as indicated, including cultures of suspected sites of infection or an evaluation of immunocompetency.

Plain radiographs are particularly useful in differentiating tuberculous from nontuberculous vertebral osteomyelitis. Radiographically, pyogenic osteomyelitis is characterized by early disc space narrowing and radiolucency of the vertebral end plates. Within 1 to 2 months end plate radiodensity increases and may progress to a spontaneous fusion over a 6-month to 24-month period. In contrast, tuberculous osteomyelitis is suggested by maintenance of disc space height and surrounding radiolucency which may persist for years.¹ Spontaneous autofusion of the involved vertebral bodies is uncommon, accounting for the more frequent occurrence of spinal deformity seen in tuberculous osteomyelitis. Other modalities of evaluation include bone scan and gallium scan, both of which are sensitive in the early detection of occult infections. Recently, MRI has been advocated as both a sensitive and specific test in the evaluation of spinal osteomyelitis.⁶ Although MRI may be useful in the evaluation of associated neural compromise, myelography and postmyelographic CT scans remain the gold standard for evaluation of the spinal canal and its contents.

Despite the many advances in imaging techniques, definitive diagnosis still relies upon biopsy and culture. Alternative approaches for biopsy include CT guided, or fluoroscopically guided, aspiration or Craig needle biopsies.² If percutaneous biopsy techniques are unsuccessful, then open biopsy is indicated. Selection of ideal antibiotic therapy is based upon culture and sensitivity results. Initial treatment of pyogenic vertebral osteomyelitis consists of a 6-week course of antibiotic therapy. Serial determinations of serum antibiotic levels are required to administer safe, yet sufficient, antibiotic dosage. Hepatic and renal function are carefully monitored for evidence of antibiotic toxicity. After a short course of bed rest, the patient is mobilized in an oyster shell brace which provides comfort and facilitates ambulation. Following the initial 6-week course of intravenous antibiotics, a prolonged course of oral antibiotics is often required. An end point for antibiotic treatment is determined by an ongoing evaluation of the clinical symptoms, serial laboratory studies, and radiographic evaluations. In particular, an ESR below 20 is a useful guide in determining satisfactory treatment response. Recurrence of the infection



Fig 3 — AP radiograph demonstrating vertebral body resection and fibular strut graft prior to posterior instrumentation.

may occasionally be treated successfully with intravenous antibiotics; however, patients who fail a course of antibiotic treatment must be seriously considered for surgical intervention.

The indication for operative intervention in pyogenic vertebral osteomyelitis is failure of conservative therapy. This may be the result of (1) inadequate response to intravenous antibiotics; (2) progressive neurologic deficit; (3) loss of structural stability in the spine; and/or (4) failure to obtain adequate cultures using closed means. Failure of conservative therapy is defined on the basis of both symptoms and objective evaluation. Persistent sepsis despite ongoing antibiotic therapy, or continued fever and pain following the completion of antibiotic therapy are characteristic.

Adequate evaluation is often complicated by the fact that pyogenic vertebral osteomyelitis tends to occur in compromised hosts. These patients have multiple ongoing medical and surgical problems. Occult foci of infection other than the spine are not infrequent. Thus, it is critical that these patients be managed with a team approach

involving the medical, infectious disease, orthopaedic, and neurosurgical services.

A thorough preoperative evaluation is vital as the degree of vertebral body involvement can be more extensive than the imaging studies indicate. The presence of neural compromise must be fully assessed preoperatively as this will dictate the appropriate operative approach. If the compression arises anteriorly, decompression should be performed via an anterior approach. Alternatively, a dorsally situated epidural abscess would be more appropriately treated via a decompressive laminectomy. Preoperative myelogram, via a C1-C2 puncture, and postmyelographic CT scan are very helpful in defining the specific characteristics of a neural compressive lesion. The role of decompression directs both orthopaedic and neurosurgical treatment options, which optimizes the chance of a successful outcome.

Operative management of pyogenic vertebral osteomyelitis must fulfill three basic goals. Firstly, adequate debridement of the involved vertebral bodies and surrounding soft tissue mass. While complete resection of all infected tissue is unlikely, a good outcome requires eradication of loculated cavities and maximum reduction of the bacterial load. Secondly, any impingement upon neural structures must be relieved. Thirdly, the spine must be stabilized both over the short term and long term.

The first stage of operative intervention is an anterior debridement of the involved vertebral bodies. As the mid and upper lumbar spine is most frequently involved, adequate exposure most often requires a thoracoabdominal approach to the spine. Infections involving only the lower lumbar vertebrae may be successfully managed via a retroperitoneal flank approach; however, unexpected cephalad extension of the infectious process may complicate the use of this approach. Only with an adequate exposure can the vertebral bodies be safely resected and the canal decompressed. Debridement is often limited by the proximity of neurovascular structures or the desire to maintain the structural integrity of the spine. Debridement should be as thorough as possible within these constraints.

Resection of one or more vertebral bodies is often required. In this situation, the stability of the anterior column of the spine is maintained by placement of a strut graft over the length of the resection. Strut graft donor site may include autologous iliac crest, vascularized or nonvascularized fibula, or vascularized rib graft (Fig 3). Bone bank

Pyogenic Infection of the Spine

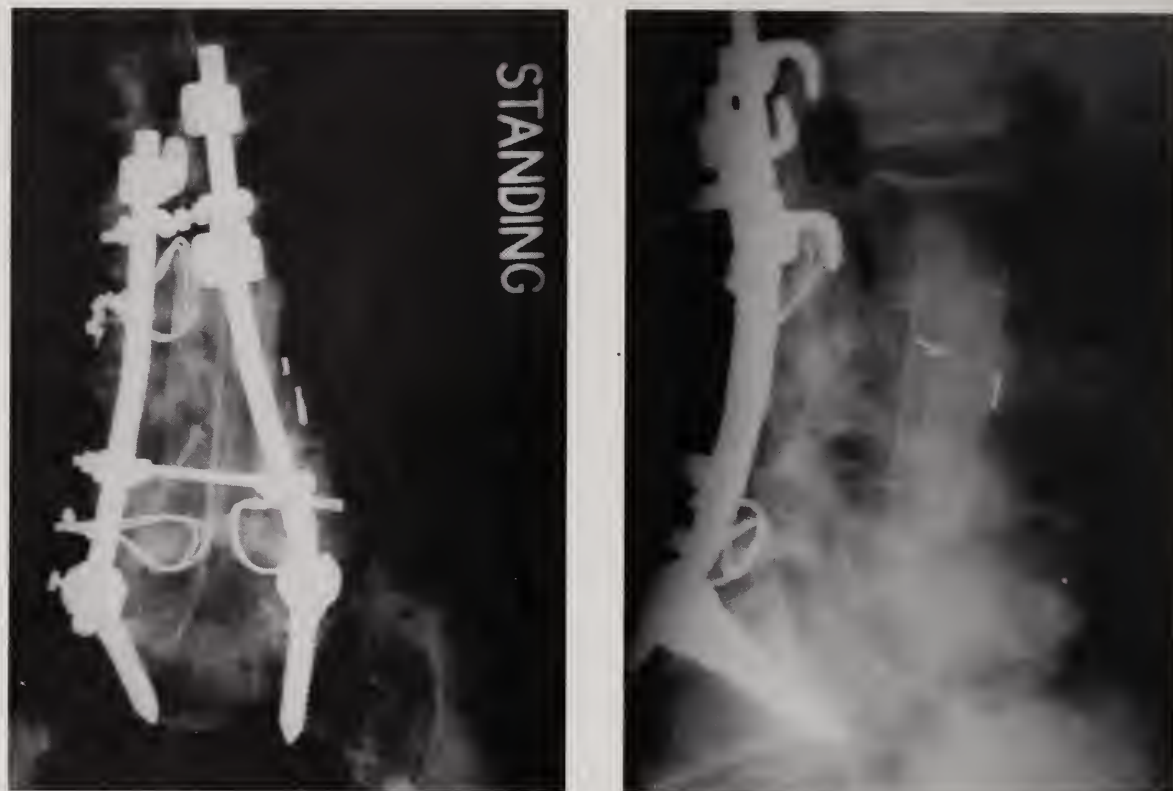


Fig 4 — A and B. AP and lateral radiographs demonstrating final construct with posterior instrumentation stabilizing the anterior fibular strut graft.

bone using fibula or femur provide alternative sources. Autologous bone is preferable if a suitable donor site is available. Because the infection is unlikely to be completely eradicated by the debridement, concomitant anterior fixation using instrumentation is avoided.

Postoperatively, the patient is placed in an oyster shell (TLSO) brace and managed at bed rest. Since the graft was not stabilized with instrumentation anteriorly, strict adherence to log rolling precautions is critical. Flexion and extension, such as with sitting, or torque, such as with twisting, might lead to graft dislodgement. Intravenous antibiotics are administered as guided by culture results. If intraoperative tissue cultures are unrevealing, the patient is treated with broad spectrum coverage to cover likely gram positive and gram negative pathogens. This regimen is maintained for approximately 2 weeks, after which time posterior instrumentation and fusion is performed. The choice of a 2-week interval represents a compromise between the risks incurred by prolonged bed rest versus the risks of implantation of instrumentation in the setting of ongoing

infection.

The posterior procedure must provide both immediate and long term stabilization. Immediate stabilization is achieved by implanting an instrumentation system which locks in the anterior strut graft and thus increases both anterior and posterior spinal stability. This allows the patient to be safely mobilized with the assistance of external bracing. In general, pedicle screw fixation, or a combination of pedicle screw and segmental instrumentation using hooks and rods, provides the most stable fixation (Fig 4). Often, the limiting factor is bone quality and strength of the hardware-bone interface. Long term stability is achieved by bony fusion, not instrumentation, as metal will loosen or fracture under repeated loads. For this reason, the quality of posterior fusion is of the utmost importance. Autologous graft obtained from the iliac crest is the recommended harvest site; however, this option may be limited by the patient's medical condition, inadequate quality of the patient's own bone, or prior graft harvest. If necessary, fusion can be undertaken using allograft bone or a combination of autolo-

gous and allograft bone.

Following posterior stabilization and fusion, the patient is mobilized in the oyster shell brace; however, activity is limited to lying flat or standing for 6 to 12 weeks, as sitting exposes the instrumentation and grafts to unduly high stress. Prolonged rehabilitation may be required, depending upon the degree of preoperative debilitation and the extent of neurologic deficit. Intravenous antibiotics are administered for 6 weeks postoperatively. Clinical and laboratory parameters are assessed in order to determine the need for longer term intravenous or oral antibiotics. Limitation of activities and bracing are continued until bone graft incorporation is noted on follow-up radiographs, at which point the patient is weaned from the brace and activities are increased. This process may not occur until 6 to 12 months postoperatively.

Pyogenic vertebral osteomyelitis is more likely to be controlled than cured. The patient population is characterized by a high incidence of underlying illness which complicates their treatment. Fortunately, most cases can be treated successfully with antibiotic therapy, leading to spontaneous fusion. If conservative therapy fails, progression of the infectious process can be dramatic. Surgical intervention is a formidable undertaking which may involve multiple operations and be associated with considerable risks. Nonetheless, with close cooperation between the medical, orthopaedic and neurosurgical services, a successful outcome can usually be achieved.

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Information for Authors

Manuscripts — Articles will be accepted for consideration with the understanding that they are original and are contributed solely to this *Journal*. The transmittal letter should designate one author as correspondent and include the author's address and telephone number. Receipt of manuscripts will be acknowledged and unused manuscripts returned. All material is reviewed by the Board of Editors and publication of any article is not to be deemed an endorsement of the views expressed therein.

Preparation — Manuscripts should be typewritten in double spacing throughout, including references, tables, legends, quotations, and acknowledgments. Submit the original and one copy, retaining a copy for proofreading. Ordinarily articles should not exceed 3,000 words in length. Titles should include the words most suitable for indexing the article, should stress the main point, and should be short. A synopsis-abstract must accompany each manuscript. The synopsis should be a factual (not descriptive) summary of the work and should state the problem considered, methods, results and conclusions.

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Animal Rights and Experimental Medicine

Recent reports of a savage attack on Michigan State University's research complex graphically depicted the swirling controversy surrounding current medical research. There are at least two sides to every issue, and this dilemma is no different. For years the research community has substituted animals for humans to experiment with surgery, medicine, therapy, etc. Once these models proved safe and effective, human studies were begun. Not only were the researchers interested in the animals for their research value, but in addition there were standards for the care and treatment of these animals. We do not live in an ideal world, and certainly animals were sometimes abused or inhumanely treated. Nevertheless, most research centers and their directors acted responsibly and were not subject to frequent criticism.

Recently animal rights activists have highlighted numerous violations of proper animal treatment. Taken to hyperbole, these examples ignited a drive to eliminate all animal research. At first this activity took the form of government inspection and enhanced regulatory activity. Apparently this was insufficient for the most concerned activists, and occasional in-house demonstrations were scheduled to highlight perceived injustices. Gradually this appropriate concern and demonstration eroded into terrorist acts on research centers. Like

street terror, innocent victims were created. Computers full of research were destroyed, records corrupted or eliminated, machinery sabotaged, and facilities ransacked.

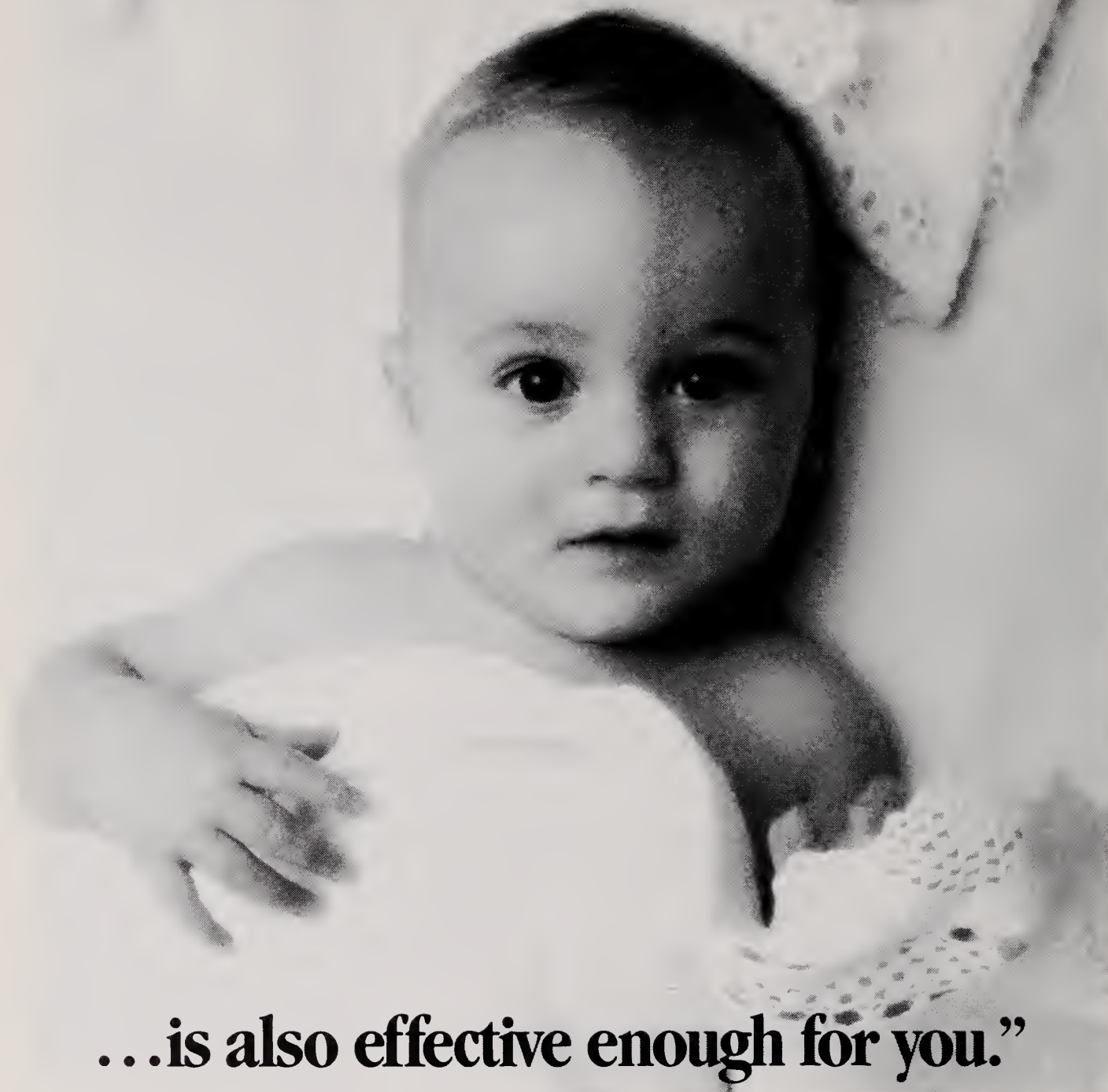
The polarity of the two sides solidified, and compromise now seems hard to expect. Certainly violent protest will never be acceptable, especially in such form as it has taken. On the other hand, animal research must be conducted not only scientifically, but absolutely in a humane way.

We physicians have a role in this unfolding drama. Certainly we have benefited from the tremendous advancements medicine has made during the past decades. Much of this research was done on animals, and their sacrifices were an unfortunate byproduct. It is true that they, the animals, have no say in what is happening to them. Their rights are subject to our discretion. We must support moral treatment for these animals, with as much ardor as we do to protect human subjects. Whether on the university level, the drug company, the manufacturing community, or wherever research on animals is being conducted, we must concern ourselves with this issue and uphold what we know is correct. This might diffuse the fire, and avoid more terror.

Stephen Z. Smith, MD

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Beryl Dodds

Family Violence

"The prevalence of violence and its consequences on society make it an issue every American should address."

The mission of the Auxiliary to the Kentucky Medical Association is to work in coalition with the Kentucky Medical Association to promote quality health care and sound health legislation. The AKMA serves as a link between county and national auxiliaries to provide leadership training and support to physician families. To accomplish this mission the AKMA encourages recruitment and retention of unified membership from all physician spouses; we provide information to counties on ways to meet community health needs; we provide leadership training opportunities; and we support health education and legislation.

During the next 4 weeks the AKMA will provide two excellent opportunities for you to become involved. On September 1 in Northern Kentucky and September 2 in Owensboro we are sponsoring family violence seminars, and on September 14 and 15 in Louisville our committees and board of directors will meet. As the spouse of a KMA member, you are encouraged to attend.

The family violence seminars will include such topics as: The Nature

and Extent of Family Violence — An Overview; Why She Stays — Why He Hits; The Effects of Family Violence on Children; and Community Resources. There will be a \$20 registration fee which includes lunch. Both seminars will begin at 9:00 AM and end at 2:00 PM.

The Family Violence Seminar in Northern Kentucky on September 1 will be held at the Four Seasons, 345 Thomas Moore Pkwy, Crestview Hills, KY 41017. Reservations may be made by contacting Ellen Hiltz, 3049 Belle Mead Lane, Edgewood, KY 41017. Her phone number is 606/341-9626.

The Family Violence Seminar in Owensboro on September 2 will be held at the Executive Inn, One Executive Boulevard, Owensboro, KY 42301. For reservation information contact Connie McCoy, 1805 Foors Lane, Owensboro, KY 42303. Her phone number is 502/683-2177.

A look at the daily newspaper will tell most people that family violence is a problem. The prevalence of violence and its consequences on society make it an issue every American should address. Those of us in the medical community should be particularly concerned, since family

violence is a pressing health issue. An article in the *Journal of the American Medical Association* reported that so many women seek medical attention for injuries resulting from family violence that it is the single largest cause of injury to women in the United States. As many as 35% of women who visit hospital emergency rooms are there for symptoms related to ongoing abuse, but perhaps as few as 5% of the victims of family violence are identified as such. What is needed is education to make people aware that family violence is more than a problem that afflicts those they read

"Those of us in the medical community should be particularly concerned, since family violence is a pressing health issue."

about. Its prevalence makes it a problem that concerned people everywhere must address. I urge you to take advantage of this opportunity

to learn more about family violence and what you can do to help break the cycle.

If you or your spouse are not currently members of the AKMA, please join us by sending a check for \$40.00 to:

Jean Wayne
AKMA Executive Secretary
301 N Hurstbourne Pky, Ste 200
Louisville, KY 40222-8512

Beryl Dodds

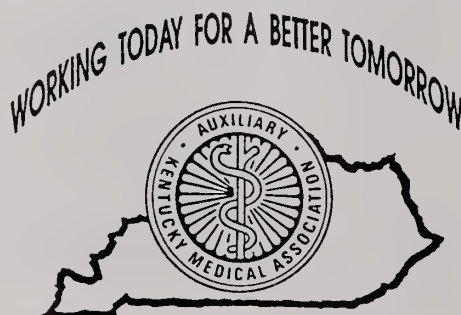
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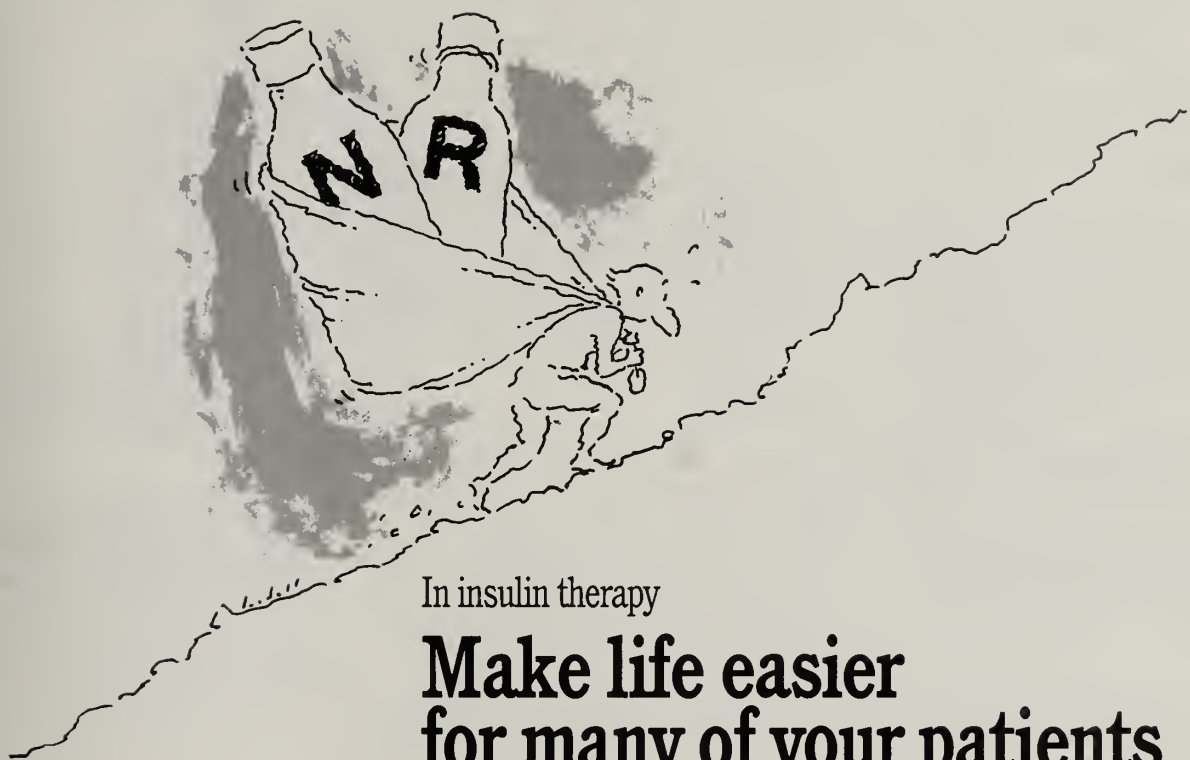
AKMA Fall Board Meeting September 14-16, 1992

The Fall Board Meeting of the AKMA will be held in conjunction with the KMA Annual Meeting. The meetings will be held at the Hyatt in downtown Louisville.

The Hospitality Suite will be open Monday, September 14, at 9:00 AM. Committee meetings will begin at 10:00 AM. The AKMA Board of Directors will meet on Tuesday, September 15, at 9:00 AM with a luncheon and style show to follow. On Wednesday at 9:00 AM we will have a jewelry display. Ann Smith (Mrs Paul) from London is an auxilian and a world traveler. She will have jewelry and accessories from all over the world, including China, Greece, and Brazil. All spouses of KMA members are invited to any or all of our activities. If you are a member of the AKMA, we will welcome you. If you are not a member, we will welcome the opportunity to get to know you as together we work today for a better tomorrow.

Information on luncheon reservations or membership may be obtained from Jean Wayne, AKMA Executive Secretary, 301 N Hurstbourne Parkway, Suite 200, Louisville, KY 40222, 502/426-6220.

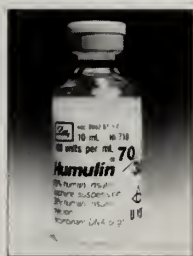




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SEPTEMBER

3-5 — Perinatal Medicine; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

19 — "Diabetic Retinopathy" presented by N. D. Radtke, MD and Humana Hospital Audubon. Category 1 of the AMA Physician's Recognition Award, 4.0 hours. Contact: Cathy Edens, 240 Audubon Medical Plaza, Louisville, KY 40217; 502/636-2823.

25-26 — 5th Annual Rehabilitation Management for the Primary Care Physician; Radisson Plaza Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

25-26 — 6th Annual Multispecialty Oculoplastic Surgery Symposium — A conjoint

symposium by specialties involved with the management of problems of the midface and ocular adnexa; Marriott's Griffin Gate Resort, Lexington, KY. Contact: Julie Burlew, RN, The Center for Advanced Eye Surgery, Humana Hospital-Lexington; 606/268-3769.

OCTOBER

25-30 — 23rd Family Medicine Review, Session III; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

29-31 — 42nd Annual Obesity & Associated Conditions Symposium, sponsored by the American Society of Bariatric Physicians, The Westin Hotel, Chicago. Contact: ASBP, 5600 S Quebec St, Ste 160-D, Englewood, CO 80111; 303/779-4833, FAX 303/779-4834.

NOVEMBER

8-12 — 96th Annual Meeting of The Ameri-

can Academy of Ophthalmology; Dallas Convention Center. Contact: The American Academy of Ophthalmology, Meetings Dept, PO Box 7424, San Francisco, CA 94120-7424; 415/561-8500.

12-15 — Southern Medical Association's 86th Annual Scientific Assembly; San Antonio, TX. Contact: SMA's Member Services Center; 800/423-4992; or 205/945-1840.

27-December 4 — 78th Scientific Assembly and Annual Meeting of the Radiological Society of North America (RSNA), McCormick Place, Chicago. Contact: RSNA, 2021 Spring Road, Ste 600, Oak Brook, IL 60521, 708/571-2670; FAX 708/571-7837.

FEBRUARY

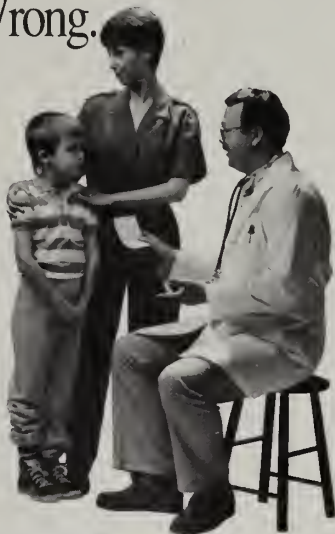
7-11 — Southeastern Surgical Congress Annual Meeting; Tarpon Springs, FL. Contact: Southeastern Surgical Congress, 1776 Peachtree St, NW, Suite 4010N, Atlanta, GA 30309; 404/607-8958.

KMA 142nd Annual Meeting

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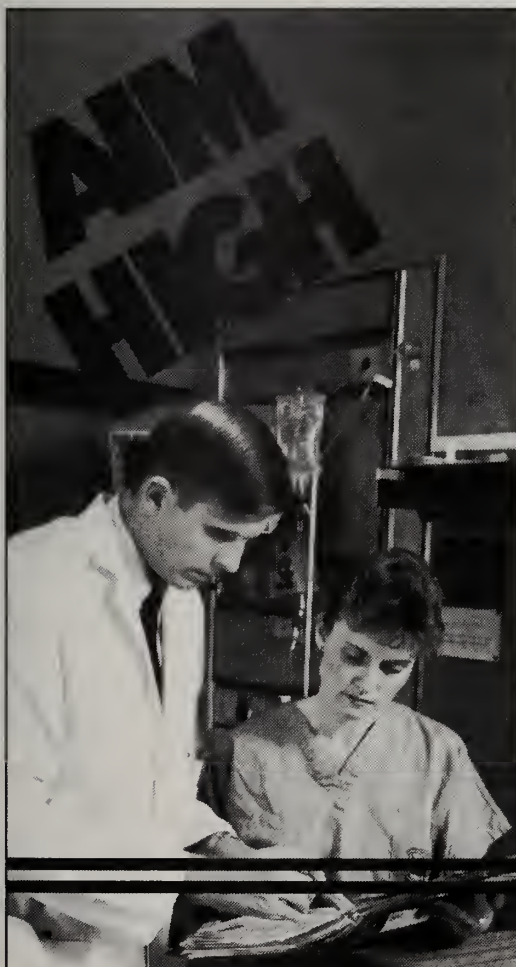
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So while there's still time, speak for yourself. Join the AMA's call for reform. Call 1-800-AMA-3211 for more information on Health Access America.

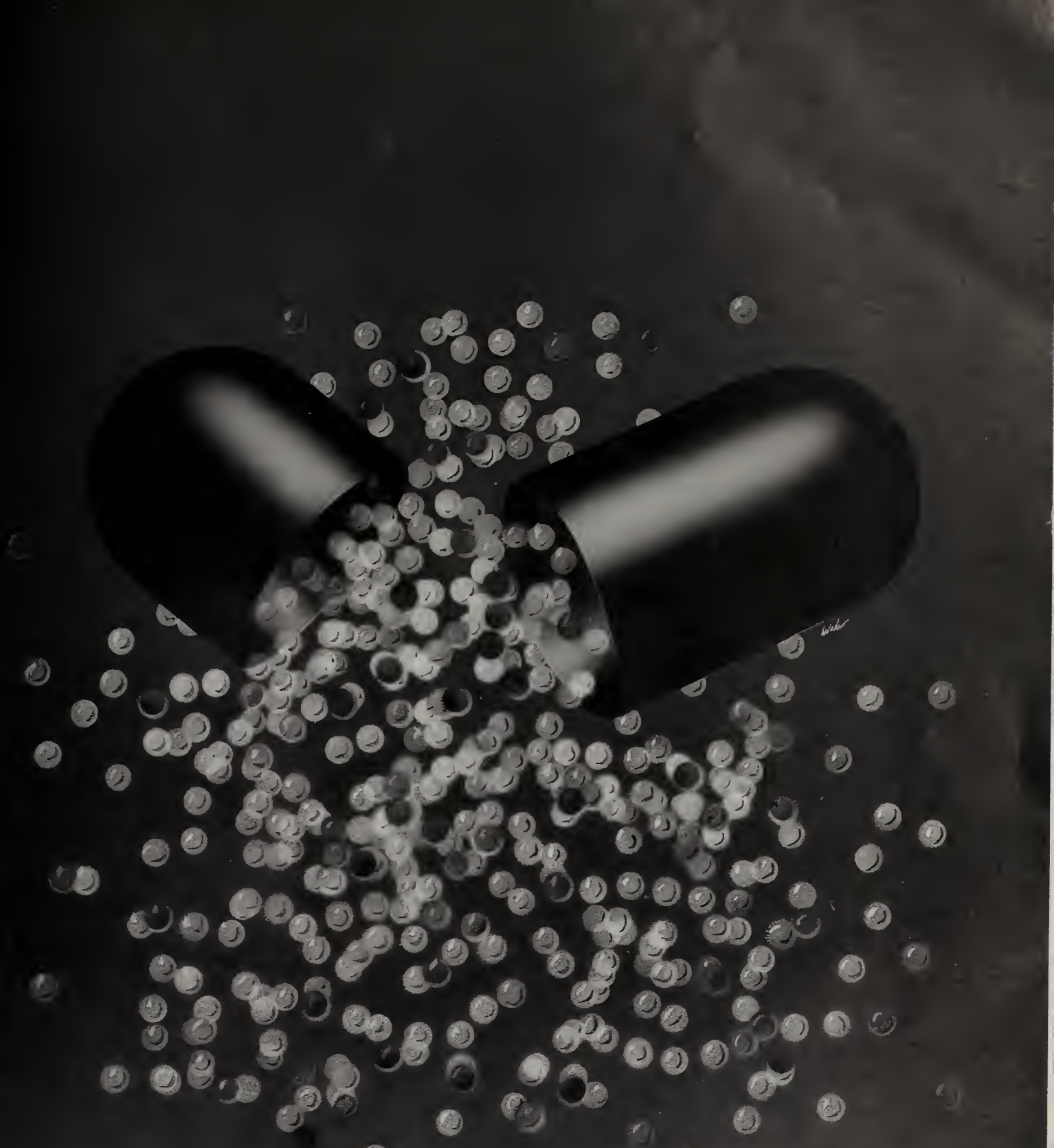
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Official Call KMA Annual Meeting

To the officers and members of the component and county medical societies of the KMA.

Meeting Place

The Annual Meeting of KMA will convene on Tuesday, Wednesday, and Thursday, September 15, 16, & 17, at the Hyatt Regency Hotel and Commonwealth Convention Center, Louisville. The first General Session will be called to order at 8:50 AM, Tuesday.

The House of Delegates

The first regular meeting of the House of Delegates will convene at 9:00 AM, Monday, September 14, in the Regency Ballroom, located in the Hyatt Hotel. The second regular business meeting will begin at 7:00 PM, Wednesday, September 16, in the Regency Ballroom.

Registration

The Registration Desk, located outside the Regency Ballroom, 2nd Floor of the Hyatt Hotel, will be open for Delegates at 7:30 AM, Monday, September 14, and at 6:00 PM, Wednesday, September 16. General registration will be held from 7:45 AM until 5:00 PM, Tuesday; 7:45 AM to 4:00 PM on Wednesday; and 7:45 AM to 3:30 PM on Thursday, at the General Registration Desk located in the lobby of the Commonwealth Convention Center.



KMA Officers 1991-92



S. Randolph Scheen, MD
KMA President

On September 16, S. Randolph Scheen, MD, Louisville, will pass the leadership of the Kentucky Medical Association to William B. Monnig, MD, of Edgewood.

Dr Scheen's extensive service to KMA began in 1967 when he was elected Secretary. In 1975, the offices of Secretary and Treasurer were combined, and Dr Scheen served in the capacity of Secretary-Treasurer until 1990 when he was named President-Elect. Current committee memberships include Scientific Program, Awards, Professional Liability Insurance, and State Legislative Activities.

Long active in organized medicine, Dr Scheen is a past Vice-President of the Jefferson County Medical Society and is also a member of the American Academy of Dermatology, Alumni Foundation of Mayo Clinic, and a regular participant on local television and radio programs.

A native of Louisville, Dr Scheen received a bachelor of science degree from the University of Louisville, followed by a medical degree from the University of Louisville School of Medicine in 1953. He served his internship at the former St. Joseph Infirmary, Louisville, and completed a residency in dermatology at Louisville General Hospital.

KMA is fortunate to have had such a strong and dedicated leader as Dr Scheen.



William B. Monnig, MD
President-Elect

William B. Monnig, MD, Edgewood, will be installed as President of the Kentucky Medical Association at the President's Luncheon on Wednesday, September 16.

Dr Monnig began his exemplary service to KMA in 1984 when he was elected Eighth District Trustee, a position he held until 1990. From 1987 until 1990, Dr Monnig also served as Chairman of the Board of Trustees, Chairman of the Executive Committee of the Board of Trustees, and as a member of the Quick Action Committee. In 1990 he was elected Vice President of KMA. His commitment to KMA has been apparent through his many committee memberships, with current obligations to the Scientific Program, State Legislative Activities, Professional Liability Insurance, Medical Insurance & Prepayment Plans, and Physician-Attorney Liaison Committees, and as Chair of the Ad Hoc Committee on KMA/KMIC Headquarters Location.

A native of Ohio, Dr Monnig earned an MD degree in 1969 from the University of Cincinnati. He completed an internal medicine internship at the University of Illinois in 1970, followed by completion of a surgical residency in 1971 and a urology residency in 1974 at the University of Cincinnati. Dr Monnig is a board certified urologist and an assistant clinical professor in the Department of Surgery at the University of Cincinnati Medical Center.



Vice-President
Ardis D. Hoven, MD
Lexington

An internist specializing in infectious diseases, Dr Hoven has chaired several committees including the Ad Hoc Committee on the Development of AIDS Guidelines, Committee on Medicare and Other Governmental Medical Programs, and since 1987 the Committee on Community and Rural Health. She also currently serves on the Professional Liability Insurance Committee and as an AMA Alternate Delegate. A 1970 graduate of the University of Kentucky College of Medicine, Dr Hoven's memberships include the American Society of Microbiology and the Fayette County Board of Health.



Secretary-Treasurer
William P. VonderHaar, MD
Louisville

A family practitioner, Dr VonderHaar has served on the Interspecialty Council, Professional Education Committee, and as a Delegate for Jefferson County for several terms. He currently serves on the State Legislative Activities, Continuing Medical Education and Professional Liability Insurance Committees. He is a charter fellow of the American College of Family Physicians and a member of the American Academy of Family Physicians. A recipient of KMA's Educational Achievement Award in 1988, Dr VonderHaar is a 1956 graduate of the University of Louisville School of Medicine.



Speaker of the House
Danny M. Clark, MD
Somerset

Dr Clark is an OB-GYN from Somerset and a 1962 graduate of the University of Cincinnati College of Medicine. He served KMA as Delegate from 1974-1980; 12th District Alternate Trustee from 1974-1980; 12th District Trustee from 1980-86; and Vice Speaker of the House from 1986-1989. Dr Clark is a member of the Committee on Maternal and Child Health and a fellow of the American College of Obstetricians and Gynecologists.



Vice Speaker of the House
C. Kenneth Peters, MD
Louisville

Dr Peters, a family practitioner, has served KMA as KEM-PAC chairman, on the Legislative Committee 15 years, and has been a KMA Delegate 21 years. He is a past president of the Jefferson County Medical Society, a Charter Fellow of the American Academy of Family Practitioners, and a member of the Jefferson County Academy of Family Practitioners. Dr Peters is a 1960 graduate of the University of Louisville School of Medicine.



KMA Delegates to AMA



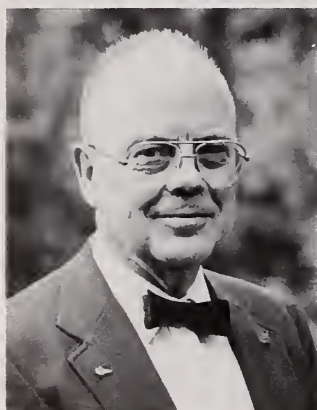
Donald C. Barton, MD
Corbin

Dr Barton, a family practitioner, was elected AMA Delegate in 1984. A past Chairman of the KMA Board of Trustees and past President of the Association, Dr Barton served as KMA Delegate from 1977-79 and AMA Alternate Delegate in 1983. He is past President of the Whitley County Medical Society; past chairman of the KEMPAC Board; and was 15th District KMA Trustee from 1978-84. Dr Barton, a 1960 graduate of the University of Louisville School of Medicine, chairs the Committee on National Legislative Activities and serves on the State Legislative Activities and Technical Advisory Committee on Physician Services.



Wally O. Montgomery, MD
Paducah

Dr Montgomery, a general surgeon, was elected AMA Delegate in 1988. He served KMA as Trustee for several years, as Vice-President, President-Elect, President, Alternate AMA Delegate, KEMPAC Chairman, and on numerous committees. He chairs the State Legislative Committee and Ad-Hoc Committee on PLL, and is a member of the National Legislative Committee. A 1962 graduate of the U of L School of Medicine, Dr Montgomery is a past KY Governor and Past President of the Kentucky Chapter of the American College of Surgeons and a diplomate of the American Board of Surgery.



Harold L. Bushey, MD
Barbourville

Dr Bushey was elected an AMA Delegate in 1989, having previously served as a KMA Delegate for 6 years; Alternate Trustee 1968-1972; 15th District Trustee 1972-1978; and Board Chairman of KEMPAC. He has served on numerous KMA committees and is currently Chairman, Technical Advisory Committee on Physician Services (Title XIX). A 1954 graduate of Rochester Medical School, Rochester, NY, Dr Bushey is an internist. He is a member of the Southern Medical Association and a past secretary of the Knox County Medical Society.



Robert R. Goodin, MD
Louisville

Dr Goodin, an internist, was elected as AMA Alternate Delegate in 1987 and served consecutive terms until his election as a Delegate in 1991. He has served KMA on numerous committees and is currently chairman of the Physician Manpower Committee and the Committee to Investigate Changing Trends in Medicine, and a member of the CME Committee. Dr Goodin earned his medical degree in 1964 from the University of Louisville School of Medicine. He is a fellow of the American College of Physicians and the American College of Cardiology.

Journal Editors

A. Evan Overstreet, MD, Editor Louisville

Dr Overstreet served on the Editorial Board for more than 6 years before becoming Editor of *The Journal* in September 1977. An internist, Dr Overstreet is a 1955 graduate of the University of Louisville School of Medicine. He is a member of the American Society of Internal Medicine, the American College of Physicians, the Transylvania Medical Society, and former President of the Louisville Society of Internists.

Daniel W. Varga, MD Louisville

Dr Varga, an internist, joined *The Journal* in 1990 as Scientific Editor. A 1984 graduate of the University of Louisville School of Medicine, Dr Varga has served as an Alternate Delegate to the KMA House of Delegates and currently is a member of the Committee on School Health, Physical Education and Medical Aspects of Sports. He is a diplomate of the American Board of Internal Medicine and a member of the American Association for the Advancement of Science, American College of Physicians, and the Southern Medical Association.

Stephen Z. Smith, MD Louisville

Dr Smith has served as Assistant Scientific Editor for *The Journal* since 1977. He also serves as book review author. A dermatologist, Dr Smith is a 1971 graduate of Johns Hopkins University School of Medicine. He is a member of the KMA Claims and Utilization Review Committee, the American Academy of Dermatology, and the American Medical Association.

Milton F. Miller, MD Louisville

Dr Miller is Associate Clinical Professor of Medicine at the University of Louisville School of Medicine. An internist, Dr Miller has served as Assistant Editor of *The Journal* since 1976, has been on the Membership Committee of the Jefferson County Medical Society, and is a former President of the medical staff at Methodist Evangelical Hospital. He is a 1954 graduate of the University of Louisville School of Medicine.

Martha Keeney Heyburn, MD Louisville

Dr Heyburn joined *The Journal* in 1986 as an Assistant Editor. An ophthalmologist, Dr Heyburn is a 1980 graduate of the University of Louisville School of Medicine. She has served the Jefferson County Medical Society as an Alternate Delegate to KMA, is a member of the American Academy of Ophthalmology, the American Medical Association, and has been a member of KMA since 1981.

Jannice O. Aaron, MD Louisville

Dr Aaron joined *The Journal* in 1990 as an Assistant Editor. A radiologist, Dr Aaron is a 1977 graduate of the University of Louisville School of Medicine. She served KMA as a Delegate from Adair County in 1985-86 and Jefferson County in 1990. A Past President of the Greater Louisville Radiological Society, she is a diplomate of the American College of Radiology and the American Society of Neuroradiology and a member of the Radiological Society of North America, New England Roentgen Ray Society, and Southeastern Neuroradiological Society.

William P. Hoagland, MD Louisville

Dr Hoagland joined *The Journal* in 1991 as an Assistant Editor. A surgeon, Dr Hoagland is a 1983 graduate of the University of Louisville School of Medicine. He has been active in the Jefferson County Medical Society and currently serves on their Business Bureau. Dr Hoagland is a member of several professional organizations including the American College of Surgeons.

KMA District Trustees



Robert P. Meriwether, MD
First District



Joseph E. Kutz, MD
Fifth District



John W. McClellan, Jr, MD
Second District



Jerry W. Martin, MD
Sixth District



William L. Miller, MD
Third District



Ronald E. Waldrige, MD
Seventh District



Lucian Y. Moreman, II, MD
Fourth District



Mark F. Pelstring, MD
Eighth District





Don R. Stephens, MD
Ninth District



Charles T. Watson, MD
Thirteenth District



Russell L. Travis, MD
Tenth District



James P. Pigg, MD
Fourteenth District



William H. Mitchell, MD
Eleventh District



Paul R. Smith, MD
Fifteenth District



David C. Liebschutz, MD
Twelfth District





KMA Delegates

Adair

Jesus C. Siady, MD, Columbia

Allen

John M. Hall, MD, Scottsville

Anderson

Ballard

Barren

Ray A. Gibson, MD, Glasgow
Morris David Moss, MD, Glasgow

Bath

Bell

Bourbon

Emmett Lee Tate, MD, Paris

Boyd

Kenneth R. Hauswald, MD, Ashland
Howard B. McWhorter, MD, Ashland
Maurice J. Oakley, MD, Ashland
Susan H. Prasher, MD, Ashland

Boyle

David C. Liebschutz, MD, Danville
Scott B. Scutchfield, MD, Danville

Bracken

Breathitt

Breckinridge

Bullitt

James R. Cundiff, Jr, MD, Shepherdsville

Butler

Calloway

Carlisle

Carroll

Kenneth H. McCrocklin, MD, Carrollton

Carter

Casey

Clark

Clay

Ira F. Wheeler, MD, Manchester

Clinton

William C. Powell, MD, Albany

Crittenden

Cumberland

Samuel Lee Rice, MD, Burkesville

Daviess

Bill J. Bryant, MD, Owensboro
William C. Harrison, MD, Owensboro
John T. Houston, MD, Owensboro
Philip B. Hurley, MD, Owensboro
Ronald M. Johnson, MD, Owensboro
Robert L. Reid, MD, Owensboro

Edmondson

Omkar N. Bhatt, MD, Brownsville

Elliott

Estill

Fayette

James W. Baker, MD, Lexington
John V. Borders, MD, Lexington
John W. Collins, MD, Lexington
Max A. Crocker, MD, Lexington
John D. Cronin, MD, Lexington
Elvis S. Donaldson, Jr, MD, Lexington
John M. Fox, MD, Lexington

W. Jeffrey Foxx, MD, Lexington
Michael D. Hagen, MD, Lexington
Bill H. Harris, MD, Lexington
Robert J. Homm, MD, Lexington
Dennis B. Kelly, MD, Lexington
Daniel E. Kenady, Sr, MD, Lexington
William D. Medina, MD, Lexington
John M. Moore, MD, Lexington
Andrew M. Moore, II, MD, Lexington
Franklin B. Moosnick, MD, Lexington
Preston Nunnelley, Jr, MD, Lexington
Barbara A. Phillips, MD, Lexington
John W. Poundstone, MD, Lexington
Andrew R. Pulito, MD, Lexington
Barry N. Purdom, MD, Lexington
John D. Stewart, MD, Lexington
Gary R. Wallace, MD, Lexington
John Robert White, MD, Lexington
Emery A. Wilson, MD, Lexington

Fleming

Floyd

Nicholas R. Jurich, MD, Prestonsburg
Raghu R. Sundaram, MD, Martin

Franklin

William H. Keller, MD, Frankfort
John M. Patterson, MD, Frankfort
Jeffrey L. Rice, MD, Frankfort

Fulton

Gallatin

Garrard

Paul J. Sides, MD, Lancaster

Grant

Graves

Charles E. Bea, MD, Mayfield
Robert D. Fields, MD, Mayfield

Grayson

Green

Greenup**Hancock****Hardin-Larue**

Nga T. Nguyen Collard, MD, Elizabethtown
David Anh Duy Dao, MD, Elizabethtown
Marion A. Douglass, Jr, MD, Magnolia
Lovegildo Garcia, MD, Elizabethtown

Harlan

Rachel R. Eubank, MD, Harlan
James K. Hurlocker, MD, Harlan

Harrison

Donald R. Stephens, MD, Cynthiana

Hart

Evelyn E. Salisbury, MD, Munfordville

Henderson

Thomas M. Gadiant, MD, Henderson
Frank K. Sewell, Jr, MD, Henderson
Rogelio A. Silva, MD, Henderson

Hickman

Bruce C. Smith, MD, Clinton

Hopkins

Wallace R. Alexander, MD, Madisonville
James M. Bowles, MD, Madisonville
William H. Klompus, MD, Madisonville
Tristan K. Lineberry, MD, Madisonville

Jackson**Jefferson**

David T. Allen, MD, Louisville
Arnold M. Belker, MD, Louisville
Susan M. Berberich, MD, Louisville
Charles J. Bisig, Jr, MD, Louisville
David H. Bizot, MD, Louisville
Harold W. Blevins, MD, Louisville
Mark H. Bronner, MD, Louisville
Philip T. Browne, MD, Louisville
William C. Buschemeyer, Jr, MD, Louisville
David E. Bybee, MD, Louisville

Stuart P. Cohen, MD, Louisville
J. William Comer, MD, Louisville
Sue A. Cutliff, MD, Louisville
John H. Doyle, MD, Louisville
Rudy J. Ellis, Jr, MD, Louisville
Samuel G. Eubanks, Jr, MD, Louisville
Mary E. Fallat, MD, Louisville
John M. Farmer, MD, Louisville
Marjorie R. Fitzgerald, MD, Louisville
Larry D. Florman, MD, Louisville
Beverly M. Gaines, MD, Louisville
Toni Michelle Ganzel, MD, Louisville
Henry D. Garretson, MD, Louisville
Katherine P. Garrison, MD, Louisville
Kamla Gauri, MD, Louisville
Darius Ghazi, MD, Louisville
B. Thomas Harter, Jr, MD, Louisville
Louis S. Heuser, MD, Louisville
Jayne L. Hollander, MD, Louisville
Walter I. Hume, Jr, MD, Louisville
Barbara Sue Isaacs, MD, Louisville
Clifford V. Jennings, MD, Louisville
John Jurige, Jr, MD, Louisville
John M. Karibo, MD, Louisville
Arthur H. Keeney, MD, Louisville
Virginia T. Keeney, MD, Louisville
Joseph E. Kutz, MD, Louisville
Robert W. Linker, III, MD, Louisville
Charles F. Mahl, MD, Louisville
Laszlo J. K. Makk, MD, Louisville
Martha T. McCoy, MD, Louisville
Robert L. McQuady, Jr, MD, Louisville
Syed M. Nawab, MD, Louisville
Catherine Newton, MD, Louisville
Robert L. Nold, MD, Louisville
Charles R. Oberst, MD, Louisville
Hobert L. Pence, MD, Louisville
K. Thomas Reichard, MD, Louisville
William M. Renda, MD, Louisville
Sheldon B. Schiller, MD, Louisville
George R. Schrodt, Jr, MD, Louisville
Robert W. Shaw, III, MD, Louisville
Kerry L. Short, MD, Louisville
Lynn T. Simon, MD, Louisville
C. Steven Smith, MD, Louisville
Rebecca Terry, MD, Louisville
Edward D. Tillett, MD, Louisville
Robert S. Tillett, MD, Louisville
Gary C. Vitale, MD, Louisville
Stephanie P. Walton, MD, Louisville
David R. Watkins, MD, Louisville
Peter H. Wayne, III, MD, Louisville
Barbara Weakley-Jones, MD, Louisville
A. Franklin White, Jr, MD, Louisville
Fred A. Williams, Jr, MD, Louisville
C. Milton Young, III, MD, Louisville

Jessamine**Johnson****Knott****Knox**

Rogelio A. Acosta, MD, Barbourville

Laurel**Lawrence****Lee**

James B. Noble, MD, Beattyville

Leslie**Letcher****Lewis****Lincoln****Livingston**

Stephen Burkhart, MD, Salem

Logan**Madison**

G. Irene Minor, MD, Berea
Richard A. Stone, MD, Richmond

Magoffin**Marion****Marshall****Martin****Mason**

Medical Challenges In An Age Of Risk



McCracken

Harry W. Carloss, MD, Paducah
Keith H. Crawford, MD, Paducah
Larry C. Franks, MD, Paducah
Stephanie R. Hatfield, MD, Paducah
David Andrew Meyer, MD, Paducah
John D. Noonan, MD, Paducah

McCreary

McLean

Meade

Raymond L. Mathis, DO, Brandenburg

Menifee

Mercer

Metcalfe

Monroe

Montgomery

Morgan

George R. Bellamy, MD, West Liberty

Muhlenberg

Nelson

Nicholas

Northern Kentucky

Charles F. Allnutt, MD, Covington
John Franklin Allnutt, MD, Villa Hills
Robert L. Baker, Jr, MD, Florence
Elbert D. Baldrige, Jr, MD, Covington
Thomas E. Bunnell, MD, Erlanger
James L. Evans, III, MD, Fort Thomas
Joseph C. Martin, MD, Erlanger
Ross McHenry, MD, Covington
George E. Miller, MD, Crescent Springs
Theodore H. Miller, MD, Edgewood
Michelle M. Murray, MD, Alexandria
Jackson O. Pemberton, MD, Hebron
Michael L. Robinson, MD, Edgewood
B. Robert Schwartz, MD, Edgewood
Steven M. Woodruff, MD, Florence

Ohio

Owen

Owsley

Pendleton

Robert L. McKenney, MD, Falmouth

Pennyrile

Emmanuel J. Battah, MD, Hopkinsville
Hank Bell, Jr, MD, Elkton
Ralph L. Cash, Jr, MD, Princeton
Harry J. Dempsey, MD, Hopkinsville
Steve Hiland, MD, Eddyville
J. Nicholas Terhune, MD, Hopkinsville

Perry

Mitchell Wicker, Jr, MD, Hazard

Pike

Krishnama K. Raju, MD, Pikeville
Elster D. Roberts, MD, Pikeville
Vivente B. Santelices, MD, Pikeville

Powell

Pulaski

Donald E. Brown, MD, Somerset
Hossein Fallahzadeh, MD, Somerset
Joseph G. Weigel, MD, Somerset

Robertson

Rockcastle

George W. Griffith, MD, Mount Vernon

Rowan

Russell

Rick S. Miles, MD, Russell Springs

Scott

James C. Cantrill, MD, Georgetown

Simpson

Michael Pulliam, MD, Franklin

Spencer

William K. Skaggs, MD, Taylorsville

Taylor

Eugene H. Shively, MD, Campbellsville

Tri-County

M. Brooks Jackson, II, MD, Shelbyville
Jeffrey N. Sharpe, MD, Louisville
David W. Wallace, MD, Shelbyville

Trimble

Roderick H. MacGregor, MD, Bedford

Union

Wallas N. Bell, MD, Morganfield

Warren

Craig Alvin Beard, MD, Bowling Green
Jane R. Bramham, MD, Bowling Green
John D. Gover, MD, Bowling Green
Paul J. Parks, MD, Bowling Green

Washington

Charles D. Howard, MD, Springfield

Wayne

Webster

Whitley

Wolfe

Woodford

KMA Hospital Medical Staff Section

William D. Pratt, MD, London

KMA Resident Physicians Section

Vincent P. Tanamachi, MD, Covington

KMA Student Section

Mark Cannon, Lexington
David Verst, Louisville

Elections

Nominating Committee to Meet Monday, September 14

The KMA Nominating Committee will hold an open meeting at the close of the first meeting of the House of Delegates, Monday, September 14, in the Regency Ballroom of the Hyatt Regency Hotel. Any KMA member may confer with the Committee during this meeting.

The report of the Nominating Committee will be posted in the general assembly hall at the conclusion of the first general session, Tuesday morning, September 15.

Nominations may be made from the floor during the second meeting of the House of Delegates, Wednesday evening, September 16, in the Regency Ballroom. The House will vote on the nominees at this meeting.

Members of this Committee are: John D. Noonan, MD, Paducah, Chairman; J. William Comer, MD, Louisville; Kenneth R. Hauswald, MD, Ashland; Dennis B. Kelly, MD, Lexington; and G. Irene Minor, MD, Berea.

Nominations should be sent before the Annual Meeting to the KMA Headquarters Office, Attention, Nominating Committee.

House to Elect New Officers During Annual Meeting

KMA officers for the 1992-93 Association year will be elected by the House of Delegates at the close of its final meeting, Wednesday evening, September 16. Officers to be elected from the state-at-large are:

Office	Year
President-Elect	1 Year
Vice President	1 Year
Speaker, House of Delegates	3 Years
*Danny M. Clark, MD Somerset	
Vice Speaker, House of Delegates	3 Years
*C. Kenneth Peters, MD Jeffersontown	
Delegates to AMA	2 Years
*Wally O. Montgomery, MD Paducah	
*Robert R. Goodin, MD Louisville	
Alternate Delegates to the AMA	2 Years
*Ardis D. Hoven, MD Lexington	
*Bob M. DeWeese, MD Louisville	
*Incumbent	

Election of Trustees and Alternate Trustees

The House of Delegates will elect five District Trustees and five Alternate Trustees at its second regular meeting, Wednesday, September 16. Nominations will be made by the Delegates from the electing Districts at a meeting following the first meeting of the House on Monday, September 14.

The Nominating Committee will report at the close of the first scientific session on Tuesday, September 15. Further nominations may be made from the floor at the final meeting of the House on Wednesday evening, September 16. All nominations are considered and acted upon by the Delegates at this final meeting.

Districts electing Trustees for 3-year terms are: **1st District** (incumbent, Robert P. Meriwether, MD, Paducah); **3rd District** (incumbent, William L. Miller, MD, Greenville); **4th District** (incumbent, Lucian Y. Moreman, MD, Elizabethtown); **12th District** (incumbent, David C. Liebschutz, MD, Danville); and **14th District** (incumbent, James R. Pigg, MD, Pikeville).

Districts electing Alternate Trustees are the same as those electing Trustees. Incumbents are: 1st District, Dan R. Miller, MD, Murray; 3rd District, Charles R. Dodds, MD, Earlington; 4th District, Salem M. George, MD, Lebanon; 12th District, Scott B. Scutchfield, MD, Danville; and 14th District, N. Roger Jurich, MD, Prestonsburg.

Trustees in the 1st and 3rd Districts are eligible for reelection, while the Trustees in the 4th, 12th, and 14th Districts have served two full, consecutive terms and are not eligible for reelection.

Alternate Trustees in the 1st, 3rd, and 14th Districts are eligible for reelection, while the Alternate Trustees in the 4th and 12th Districts have served two full, consecutive terms and are not eligible for reelection.



Reference Committee Activity

Speakers Danny M. Clark, MD, Somerset, and C. Kenneth Peters, MD, Louisville, will assign all officers' and committees' reports and Resolutions to one of six Reference Committees at the first meeting of the KMA House of Delegates at 9:00 AM, Monday, September 14. A brief session for Reference Committee Chairmen will be held at 12:00 noon Monday in the Derby Room, located in the Hyatt Hotel. Any KMA member wishing to testify on any Resolution or report is urged to be present for the Reference Committee meetings which will be held at 1:30 PM Monday, September 14, on the first floor of the Hyatt Hotel. These open sessions

will last at least one hour in order for all who wish to speak to be heard. Following the open hearings, the Committees will go into executive sessions to study the reports, review the testimony, and write their reports to the House.

The Committees' recommendations will be presented at the final meeting of the House, Wednesday evening, September 16 in the Regency Ballroom, Hyatt Hotel.

Appointments to Reference Committees and Credentials Committee and Tellers are now being finalized by the Speakers.

If your society has not yet submitted the name of your Delegate(s) to the

Headquarters Office, you should do so immediately, as only those names recorded in the office can be considered for appointment to one of the Reference Committees and be listed as official county representatives.

A complete listing of members who will be serving on the six Reference Committees and the location of the Reference Committee meetings will be published in the September issue of the *KMA Journal*.

Anyone desiring names of Reference Committee members before the September issue is published should contact the Headquarters Office.

Make Your Reservations Now

It is important that you begin to make your room reservations as soon as possible for the KMA Annual Meeting, September 14-17. The Hyatt Regency Louisville will be the Headquarters Hotel (Phone 502/587-3434). In making your reservations, remember the first House of Delegates meeting will be Monday, September 14. Be sure and identify yourself as a KMA meeting attendee to receive the special convention rate — Single — \$68/Double — \$78.

Capsule Schedule of 1992 Annual Meeting

CC = Commonwealth Convention Center
HH = Hyatt Regency Hotel

Sunday, September 13

9:00 AM KMA Executive Committee Meeting
12:30 PM KMA Board of Trustees Meeting & Lunch

Derby Room-HH
Regency Ballroom South

Monday, September 14

7:30 AM Registration for House of Delegates
7:30 AM Continental Breakfast for House of Delegates
hosted by JCMS
9:00 AM First Meeting, KMA House of Delegates
10:00 AM Auxiliary Committee Meetings
12:00 NOON Luncheon, Reference Committee Chairmen
2:00 PM Reference Committee Meetings
6:00 PM KEMPAC Reception & Dinner

Outside Regency Ballroom-HH
Regency Ballroom Foyer-HH
Regency Ballroom-HH
Seneca-HH
Derby Room-HH
Various Meeting Rooms-HH
Regency Ballroom-HH

Tuesday, September 15

7:00 AM KEMPAC Board Breakfast Meeting
7:00 AM Maternal Mortality Committee Breakfast
7:45 AM Registration
8:00-9:00 AM Free Coffee & Danish
8:00-9:00 AM Reference Committee Report Signing
8:50 AM Opening Ceremonies, First Scientific Session
9:00 AM Auxiliary Fall Board Meeting
12:00 NOON Young Physicians Luncheon
12:00 NOON Luncheon Meeting, Executive Committee &
Reference Committee Chairmen
1:00 PM MSS/RPS Annual Meeting
1:30 PM Specialty Group Sessions . . . (Seven Specialty
Groups will meet simultaneously at this time.
Their programs begin on page 415)

Belmont-HH
Aqueduct-HH
Registration Area-CC
Exhibit Hall-CC
Churchill Downs-HH
General Sessions Area-CC
Conference Theatre-HH
Keeneland Suite-HH
Kentucky Suite-HH
Lower Level-CC
Various meeting rooms-CC

Wednesday, September 16

7:15 AM KMIC-sponsored Breakfast
7:45 AM Registration
8:00-9:00 AM Free Coffee & Danish
8:50 AM Second Scientific Session
11:50 AM President's Installation/Awards Luncheon
2:15 PM Specialty Group Sessions . . . (Eight Specialty
Groups will meet simultaneously at this time.
Their programs begin on page 417)
3:00 PM KMA Board of Trustees Meeting & Dinner
7:00 PM Second Meeting, KMA House of Delegates

Regency Ballroom-HH
Registration Area-CC
Exhibit Hall-CC
General Sessions Area-CC
Regency Ballroom-HH
Various meeting rooms-CC
Regency Ballroom South
Regency Ballroom-HH

Thursday, September 17

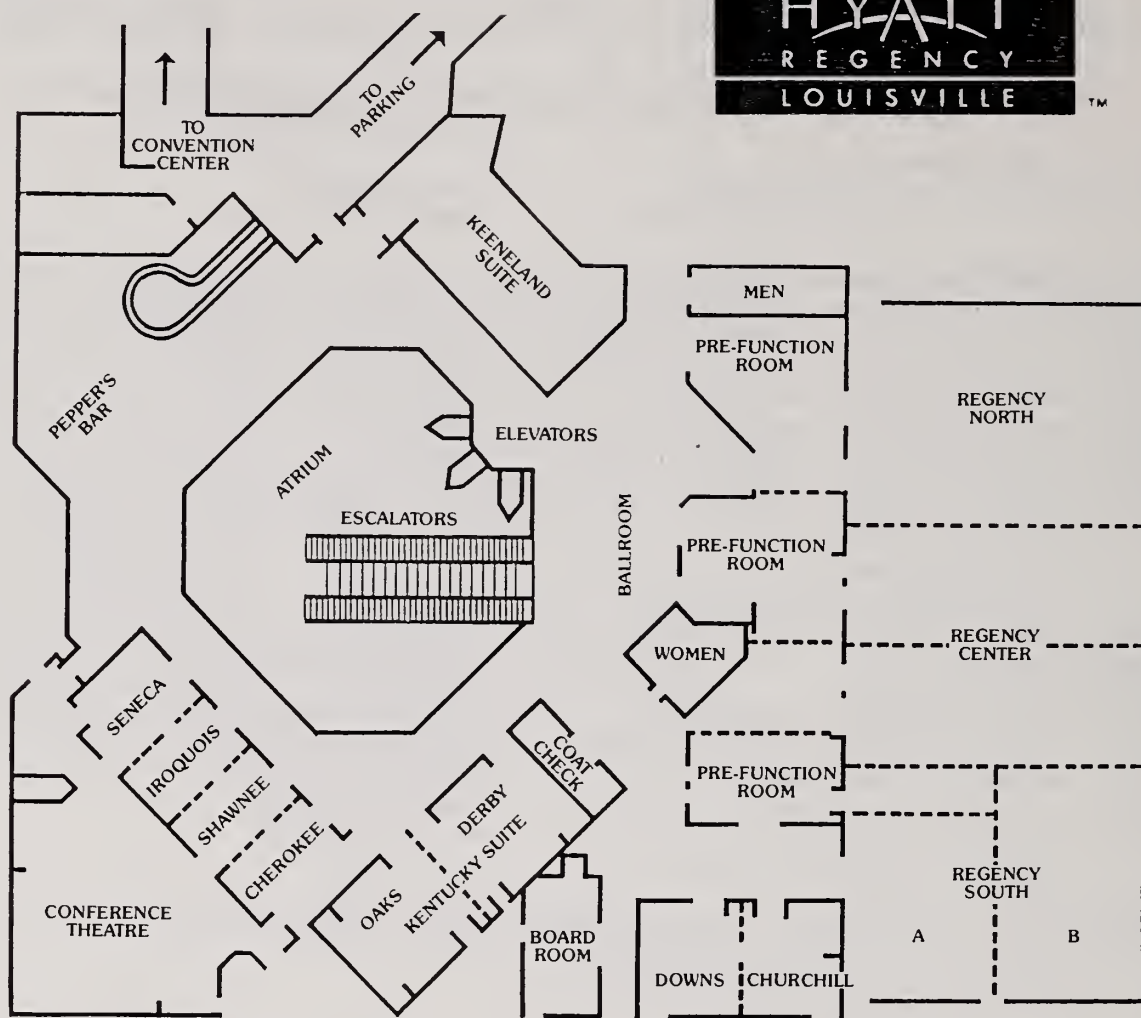
7:45 AM Registration
8:00-9:00 AM Free Coffee & Danish
8:50 AM Third Scientific Session
12:00 NOON KMA Board of Trustees Luncheon Meeting
1:30 PM Specialty Group Sessions . . . (Eight Specialty
Groups will meet simultaneously at this time.
Their programs begin on page 419)

Registration Area-CC
Exhibit Hall-CC
General Sessions Area-CC
Regency Ballroom South-HH
Various meeting rooms-CC

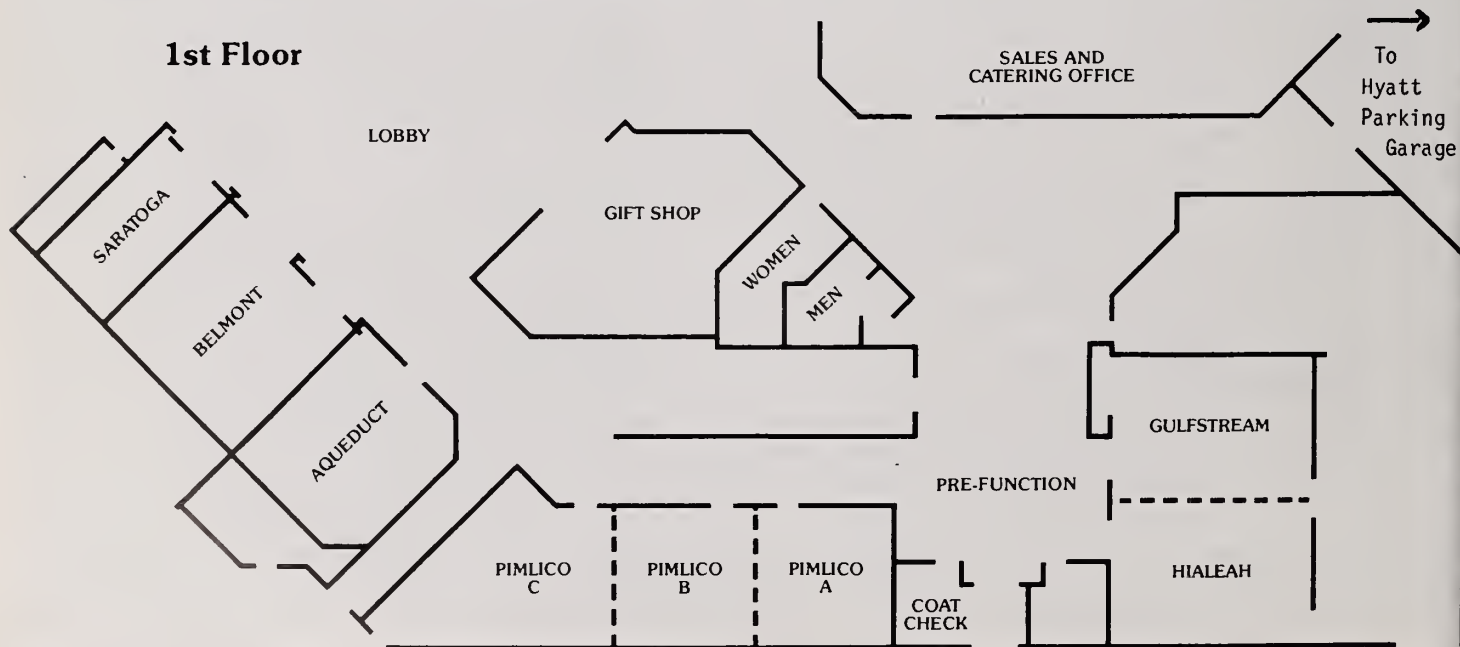
A 30-minute intermission has been scheduled during each morning Scientific Session and each afternoon Specialty Group Session for visiting Exhibits.

HOTEL FUNCTION SPACE

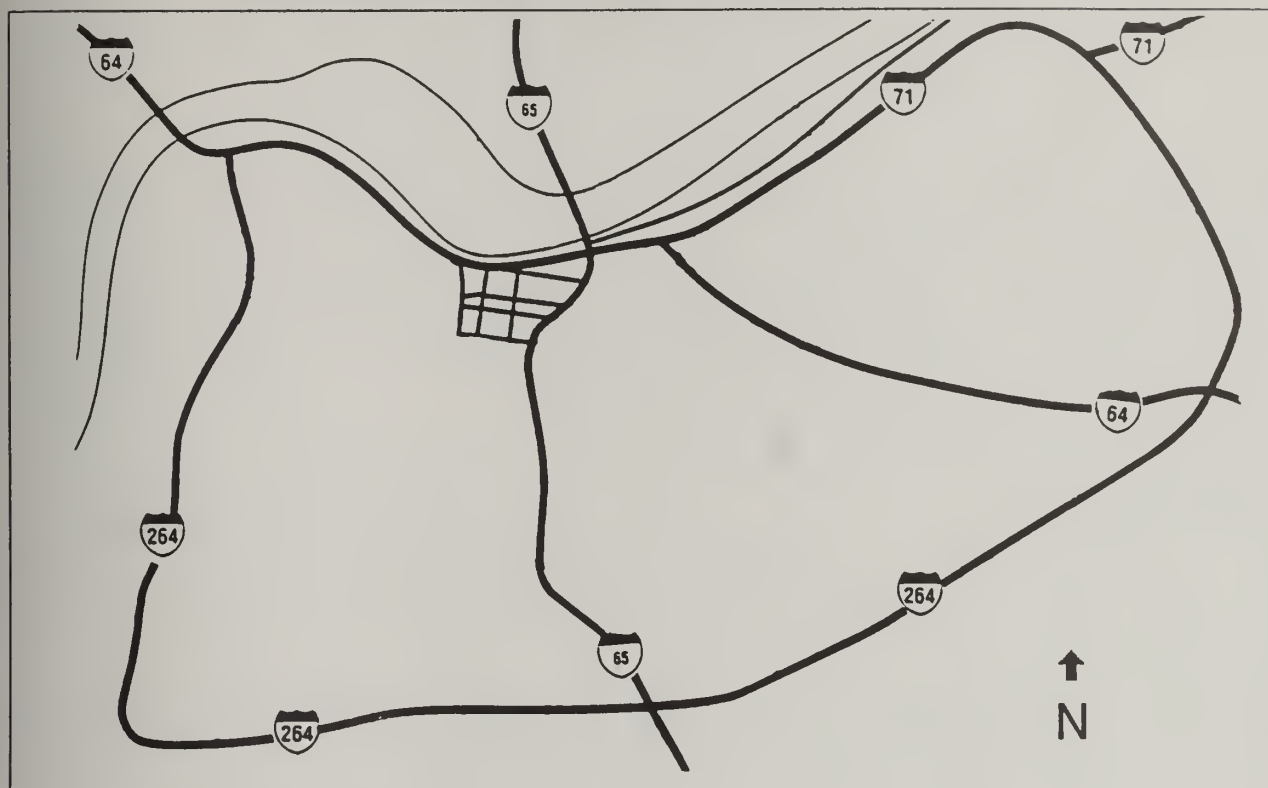
2nd Floor



1st Floor



TO REACH HYATT REGENCY/ COMMONWEALTH CONVENTION CENTER

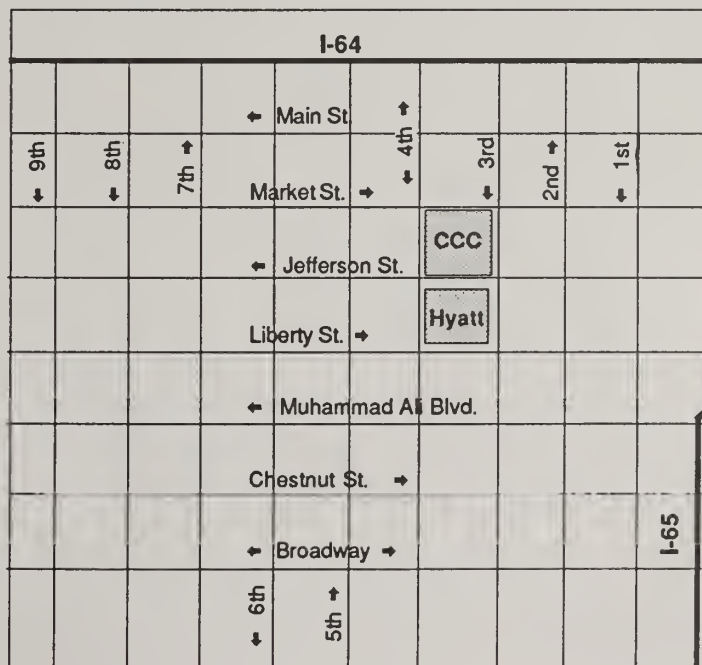


MAP INSET OF DOWNTOWN LOUISVILLE

From I-64/I-71 Westbound:
Take 3rd St. exit, go south
on 3rd, turn right on Jefferson.

From I-64 Eastbound:
Take 9th St. exit, go south
on 9th, turn left on Market.

From I-65 Northbound:
Take Muhammad Ali Blvd.
exit, go west on Muhammad
Ali, turn right at 2nd St., turn
left at Jefferson.



PARKING MAP



Annual Meeting Special Features



Medical Challenges In An Age Of Risk

KMA Annual Meeting • Sept 13-17 • Hyatt Regency
Commonwealth Convention Center • Louisville, KY

1992 Annual Meeting Honors Past President David O. Hancock, MD

The 1992 Annual Meeting of the Kentucky Medical Association will be officially titled "The David O. Hancock Meeting" in remembrance of the 1912 President of the Association. The tradition of honoring a past president of KMA and other distinguished physicians originated with the 1935 Annual Meeting. Eugene H. Conner, MD, Louisville, KMA Historian, has written a biography on Dr Hancock that begins on page 411.

Scientific Sessions are scheduled for September 15, 16 & 17 at the Commonwealth Convention Center in Louisville. The theme for the 1992 scientific session is "Medical Challenges in an Age of Risk." Both the presentations and discussion periods will contribute to the continuing medical education of Kentucky's physicians.

Twenty-three Specialty Groups will hold meetings on the afternoons of September 15, 16 & 17. Beginning at 1:30 PM on Tuesday and Thursday and 2:15 PM on Wednesday, they will be held in the meeting rooms located on the lower level of the Commonwealth Convention Center. Individual programs of specialty societies are listed in this issue. All general sessions will be held in the mornings. Specialty groups will meet all three afternoons with no general sessions scheduled during these specialty group meetings. All KMA members are invited to attend any specialty meetings.

Scientific and Technical Exhibits will display new medical products, services, and techniques in the Exhibit Hall, located in the Commonwealth Convention Center, during the 1992 Annual Meeting. Members and guests are urged to take the opportunity to view products of interest at the 30-minute intermissions scheduled during each general and specialty session.

The KMA House of Delegates will meet twice during the Annual Meeting. The first meeting of the House will be held at 9:00 AM, Monday, September 14, in the Regency Ballroom located in the Hyatt Hotel. The final meeting will be held Wednesday, September 16, at 7:00 PM, also in the Regency Ballroom. Officers for the 1992-93 Associational year will be elected at the second meeting.

The President's Installation & Awards Luncheon will be held on Wednesday, September 16, in the Regency Ballroom located in the Hyatt Hotel. The luncheon will include the presentation of KMA awards and the installation of the 1992-93 President, William B. Monnig, MD, Edgewood.

KEMPAC

30th Annual
Seminar-Dinner
is fast approaching!!!

Senatorial Candidates



State Senator
David Williams



U.S. Senator
Wendell Ford

have been invited as guest speakers

Monday, September 14, 1992
6 PM EDT — Reception — Regency Ballroom
7 PM EDT — Dinner — Regency Ballroom
(Program to Follow Dinner)
Hyatt Regency Hotel
Louisville, KY

MARK YOUR CALENDAR! ORDER TICKETS NOW!



KMIC-Sponsored Breakfast

7:15 - 8:30 am

Wednesday, September 16

Regency Ballroom B

2nd Floor

Hyatt Regency Hotel - Louisville

"Everyone Welcome!"

KEMPAC TICKETS ARE ON SALE NOW! They can be purchased from the KEMPAC Headquarters Office for \$30.00 each. Make check payable to KEMPAC and mail to: KEMPAC, 301 N Hurstbourne Parkway, Suite 200, Louisville, Kentucky 40222

30th KEMPAC Seminar-Dinner — \$30.00 per person.

NAME _____

ADDRESS _____

CITY _____

AMOUNT ENCLOSED \$ _____ NO. OF TICKETS _____

Attention: All Medical Office Managers & Staff

Electronic Billing Seminar

Wednesday, September 16, 1992

1:00 pm

Meeting Rooms 110 & 111

Lower Level

Commonwealth Convention Center

Louisville, Kentucky

Electronic Media Claims (EMC)

vs

Paper Claims

The Decision is Yours!!!

Electronic claims submission offers a number of advantages over filing paper claims, including:

- * Faster claims processing*
- * Faster payment turnaround*
- * Faster turnaround of rejected claims*
- * Eliminates the volume of claim forms for BCBS and Medicare*

To learn more about Electronic Claims Submission, plan to attend this seminar during KMA's Annual Meeting. Blue Cross and Blue Shield/Medicare EMC Specialists will give the presentation and will be glad to answer any questions you might have regarding Electronic Claims Submission. KMA is offering this workshop free to all medical office and clinic staffs in the state. No pre-registration is necessary. Plan to attend!

Medical Office And Clinic Staff Claims Prevention Program

Kentucky Medical Insurance Company will offer a special claims prevention workshop for medical office and clinic staff during the KMA Annual Meeting. A similar workshop, based on the workbook entitled *Risk Prevention Skills for Medical Office and Clinic Staff*, was presented to over 1500 medical office/clinic staff members in 1991. Over 90% of those participants evaluated the overall program as above average to excellent. The 1992 offering will be based upon the same proven concepts the workbook outlines. However, the workshop has been redesigned to include not only the popular hypothetical situation discussion, but additional information as well.

Participants will be mailed a self-study workbook and accompanying answer sheet which should be completed before the workshop. The answer sheets will be collected at the workshop, and each participant will be mailed an individual score report.

The cost, which includes the workbook, scoring service, and workshop, is \$25 per office/clinic staff member employed by physicians insured by Kentucky Medical. For office/clinic staff whose physician employer is not insured by Kentucky Medical, the cost is \$35 per person.

The workshop is scheduled from 9:00 to 11:00 AM on Wednesday, September 16, 1992, at the Hyatt Regency Hotel, Louisville. In order to register, please call Kentucky Medical Insurance Company either toll free at 800/467-1858, or in Louisville, 339-5771. Prompt registration is encouraged.



DAVID O. HANCOCK
1912

David Ottawa Hancock, MD 1862-1916

At the Annual Meeting of our Kentucky State Medical Association held in Paducah on 23-26 October 1911, David O. Hancock, MD, of Henderson, Kentucky, became President-Elect and for that meeting and the ensuing year presided as Vice President.¹

Doctor Hancock was a native of Henderson County, Kentucky,² and served his medical preceptorship under William A. Yohn, MD, of Valparaiso, Indiana.³ He had attended the spring and summer sessions of the Kentucky School of Medicine in Louisville during the year 1891 and graduated in June 1891.⁴

He was licensed 2 years later on 3 October 1893, and registered his diploma in the county court several days later. As was sometimes the custom, he may have spent some part of several years gaining experience as a hospital house officer, which would explain the 2-year hiatus between his graduation and registration of his diploma and license.

Beginning practice in his native county, he soon became an active par-

ticipant in the Henderson County Medical Society and served as secretary for several terms and as its President. He presented several papers that were published in the *KMJ* and participated in the discussion of the presentations of others. In one of his addresses when he was a participant at a meeting of the Association of County Secretaries which followed the 1911 KMA meeting in Paducah, he ably stated his philosophy concerning the duties of the president of a medical society — to speak, lead discussions, act as arbiter in disputes, and visit fellow members.⁵ This philosophy he had already followed, as his published addresses in *KMJ* demonstrate a current knowledge of his subject as then published and taught. There was in Doctor Hancock a then unusual spirit to share by publication some of his addresses. They are "Uremia,"⁶ "Natural Defenses of the Body,"⁷ and a splendid address, "Medical Missions,"⁸ presented to the Board of Missions of the Methodist Church. Herein he combined his zeal for his church and his deep concern for the welfare of his fel-

low man, both at home and abroad. He used this forum to speak of the fight against tuberculosis in Kentucky and the whole United States. He also revealed a thorough knowledge of public health problems that needed the attention of all citizens on both local, state, and federal levels.

Doctor Hancock was Chairman of the KMA Committee on Antituberculosis Campaign in 1908-09, and presented the Committee's recommendations for a public educational program, citing methods for prevention and treatment of tuberculosis, and a method of payment. This is a fine example of the leadership provided by the KMA.

In 1912, matters of public health and health care were still under control of physicians, medical societies were the mainstay of continuing medical education, and the opinion of the members were sought in the preparation of public health laws. Doctor Hancock assumed the Presidency of KMA on 28 October 1912 at the Annual Meeting in Louisville, at which time he gave his "President's Address."¹⁰ He had the



foresight to urge the physicians by a united effort through their county and state medical societies to perfect the public health laws and protect the health of all citizens by effective preventive and therapeutic measures.

Although Doctor Hancock was a good man, capable practitioner, and an able President of our KMA, he was apparently a rather private person. It may be for this reason that we know very little about him or his family except that he was married and had one daughter. His obituary¹¹ in the public press of Henderson was brief and contained no personal details. His burial in Henderson's Fernwood Cemetery was private. There is a brief notice of his death in the *JAMA*,¹² but none has been located in the *KMJ*.

On the day Doctor Hancock died, 19 April 1916, President Woodrow Wilson had sent an ultimatum to Kaiser Wilhelm of Germany and the world was much destabilized by rumors of war and wartime preparations. Perhaps the international crisis coincident with his death also may account for the failure to fully recognize the contributions of this Kentucky physician who ably led our society in 1912-13.

Eugene H. Conner, MD
KMA Historian

References

1. *KMJ* 9, 905, 1911.
2. *Medical Register*, No. 1, p87. Henderson County Court Clerk's office. Copy in WPA History of Medical Aid Public Health files, Kornhauser HS Libr,

UL, Louisville, KY (1938).

3. *35th Annual Announcement Kentucky School of Medicine, Louisville. A Spring and Summer School Session of 1891.* p21.

4. *36th Annual Announcement Kentucky School of Medicine, Louisville. A Spring and Summer School Session of 1891.* p12.

5. Hancock, DO. What is the President of a County Medical Society Good For. *KMJ* 10, 18-19, 1912.

6. ——— Uremia. *KMJ* 7, 203-204, (March) 1909.

7. ——— Natural Defenses of the Body. *KMJ* 9, 301-302, (April) 1911.

8. ——— Medical Missions. *KMJ* 10, 225-228 (March) 1912.

9. Report of the Committee on Anti-Tuberculosis Campaign. DO Hancock, MD, Chairman. *KMJ* 7, 944-45 (Nov) 1909.

10. Hancock, DO: President's Address. *KMJ* 10, 838-842, (Nov) 1912.

11. "Dr. Hancock Passes Away." *Henderson Daily Gleaner*, Henderson, KY. Thursday morning, April 20, 1916. p8 col (3).

12. David Ottawa Hancock, MD. . . . *JAMA* 67, 218 (15 July) 1916.

TO ALL SENIOR AND/OR RETIRED MEMBERS OF KMA

STATE-WIDE CATO SOCIETY MEETING

9:30 A.M., WEDNESDAY, 16 SEPTEMBER 1992

THE HYATT REGENCY HOTEL, LOUISVILLE, KY.

Here is an opportunity for senior and/or retired members of KMA to meet old colleagues and make new friends at the 3rd Annual CATO Society Meeting.

The CATO Society has no officers and no dues but is an integral part of the Jefferson County Medical Society and its Senior Physicians Committee. We have meetings in Spring and Fall which are primarily for fellowship. We gather for a light meal followed by an enlightening but brief address on some informative or entertaining topic.

Our CATO Society of JCMS hosted a state-wide meeting two years ago and the senior physicians of Fayette County Medical Society had encouraging success again last year when the KMA met in Lexington.

Watch your mail for the invitation. Complete the form and share a time during breakfast with your colleagues. We look forward to visiting with you.

G.W. "Bill" Pedigo, M.D.
Chairman, State-wide CATO Society Meeting 1993

Introducing the Annual Meeting Speakers



Linda Stehling, MD
Scottsdale, AZ

Medical Consultant, Blood Systems, Inc; Associate Medical Director, United Blood Services of Arizona, Scottsdale, MD, 1970, University of Texas Medical School at San Antonio. Fellow, American College of Anesthesiologists, American Academy of Pediatrics.



Steven G. Gabbe, MD
Columbus, OH

Professor and Chairman, Department of Obstetrics and Gynecology, Ohio State University College of Medicine, Columbus, MD, 1969, Cornell University Medical College, New York. Fellow, the American College of Obstetricians & Gynecologists.



William S. Blau, MD
Chapel Hill, NC

Associate Director, Anesthesiology Pain Clinic; Coordinator, Anesthesiology Pain Therapy Program; Assistant Professor of Anesthesiology, the University of North Carolina at Chapel Hill, MD, 1987, University of North Carolina School of Medicine.



M. Joycelyn Elders, MD
Little Rock, AR

Director, Arkansas Dept of Health, MD, 1960, University of Arkansas. Recipient of National Governor's Association Distinguished Service Award 1989, and AMA National Congress on Adolescent Health Award for Outstanding Efforts on Behalf of America's Youth 1990.



Joseph D. Babb, MD
Fairfield, CT

Clinical Associate Professor of Medicine, and Chief, Section of Cardiology, Bridgeport Hospital, Bridgeport, CT. MD, 1966, Johns Hopkins University School of Medicine, Baltimore.



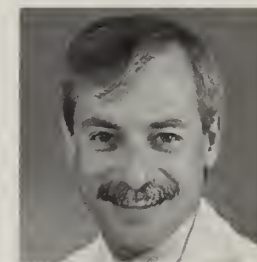
R. Doyle Stulting, Jr, MD
Atlanta, GA

Associate Professor of Ophthalmology, Department of Ophthalmology, and Associate Professor, the Winship Cancer Center, Emory University School of Medicine, Atlanta, MD, 1976, Duke University, Durham.



Mary H. McGrath, MD
Washington, DC

Professor of Surgery, Chief, Division of Plastic and Reconstructive Surgery, George Washington University Medical Center, Washington, DC. MD, 1970, St. Louis University School of Medicine.



Marc L. Eckhauser, MD
Cleveland, OH

Assistant Professor of Surgery, and Assistant Professor of Oncology, Case Western Reserve University School of Medicine, Cleveland, MD, 1977, SUNY Downstate Medical Center, Brooklyn.



John W. Ward, MD
Atlanta, GA

Chief, Reporting and Analysis Section, Centers for Disease Control, Atlanta, MD, 1981, University of Alabama School of Medicine.



Joseph E. Oesterling, MD
Rochester, MN

Assistant Professor of Urology, Mayo Clinic, Rochester, MD, 1982, College of Physicians and Surgeons, Columbia University, New York.



Theodore Rosen, MD
Houston, TX

Chief, Dermatology Service, Veterans Affairs Medical Center; Professor, Dermatology, Baylor College of Medicine, Houston, MD, 1974, University of Michigan Medical School, Ann Arbor.



Allan M. Rubin, MD
Toledo, OH

Professor and Chairman, Department of Otolaryngology-Head and Neck Surgery, Medical College of Ohio Hospital, Toledo, MD, 1979, University of Toronto.



E. Scott Medley, MD
Gainesville, FL

Clinical Assistant Professor, University of Florida, and family medicine private practice, Gainesville. MD, 1972, University of Kentucky College of Medicine. Past President and Chairman of the Board, Florida Academy of Family Physicians.



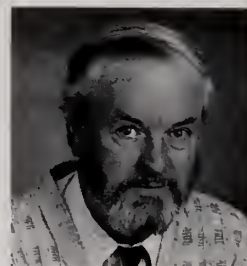
Robert H. Cofield, MD
Rochester, MN

Orthopaedic Surgeon, Adult Reconstruction, Mayo Clinic; and Professor, Mayo Medical School, Rochester. MD, 1969, University of Kentucky College of Medicine. Founding Member and Past President, American Shoulder and Elbow Surgeons.



Thomas R. Hales, MD
Denver, CO

Medical Epidemiologist, National Institute for Occupational Safety and Health, Centers for Disease Control, US Public Health Service; Assistant Clinical Professor, Dept of Preventive Medicine and Biometrics, School of Medicine, University of Colorado. MD, 1983, Case Western Reserve University, Cleveland.



James M. Turnbull, MD
Johnson City, TN

Psychiatrist, Holston Mental Health Services, Kingsport; Clinical Professor, James H. Quillen College of Medicine, Dept of Psychiatry, East Tennessee State. Bachelors of Medicine and Surgery, 1961, St. Mary's Hospital Medical School, University of London. Fellow, Royal College of Physicians of Canada and American College of Psychiatrists.



Tom R. DeMeester, MD
Los Angeles, CA

Professor of General and Cardiovascular - Thoracic Surgery; Chairman, Department of Surgery, University of Southern California School of Medicine. MD, 1963, University of Michigan School of Medicine, Ann Arbor. Fellow, American College of Surgeons, American College of Chest Physicians.

(Photos Not Available)

Henry Krakauer, MD, PhD
Bethesda, MD

Captain, US Public Health Service; and Adjunct Professor, Dept of Preventive Medicine and Biometrics, Uniformed Services University School of Medicine. MD, 1964, New York University School of Medicine. Recipient of Distinguished Service Award, Dept of Health and Human Services, in 1989; and USPHS Meritorious Service Medal in 1991.



John M. Tew, Jr, MD
Cincinnati, OH

Professor and Chairman, Dept of Neurosurgery, Cincinnati Medical Center; Co-Director, Skull Base Team, University Hospital; Chief of Neurosurgery, Children's Hospital Medical Center. MD, 1961, Bowman-Gray School of Medicine. President of LANSI (Laser Association of Neurological Surgeons International); past president of Congress of Neurological Surgeons.

P. Samuel Pegram, Jr, MD
Winston-Salem, NC

Associate Professor of Medicine, Section on Infectious Diseases and Immunology, Bowman Gray School of Medicine; Director, Infectious Diseases Specialty Clinic, Winston-Salem. Diplomate, American Board of Internal Medicine. MD, 1970, Bowman Gray School of Medicine of Wake Forest University.

John W. Georgitis, MD
Winston-Salem, NC

Associate Professor of Pediatrics, Bowman Gray School of Medicine of Wake Forest University, Winston-Salem. MD, 1976, University of Vermont College of Medicine, Burlington. Fellow, American Academy of Pediatrics, American College of Allergy, American Academy of Allergy and Immunology.

David T. Lowenthal, MD
Gainesville, FL

Professor of Medicine, Pharmacology, and Exercise Science, University of Florida; Director of Geriatric Research, Education and Clinical Center, VA Medical Center. MD, 1966, Temple University School of Medicine. Fellow, American College of Physicians, American College of Cardiology, American College of Clinical Pharmacology, American College of Chest Physicians.

Medical Challenges In An Age Of Risk

Kentucky Medical Association

Scientific Program

David Ottawa Hancock Meeting

S. Randolph Scheen, MD KMA President, Presiding

Tuesday, September 15, 1992
Morning General Session
General Sessions Area —
Commonwealth Convention Center

- 8:50 AM Opening Ceremonies
9:00 AM **"Problems & Solutions in the Management of Congestive Heart Failure"**
Joseph D. Babb, MD, Bridgeport, CT
9:20 AM To Be Announced
Tom R. DeMeester, MD, Los Angeles, CA
9:40 AM **"Screening for Gestational Diabetes Mellitus"**
Steven G. Gabbe, MD, Columbus, OH
10:00 AM **Intermission to Visit Exhibits**
10:30 AM **"New Technology to Aid Risk Reduction in Surgery: A Neurosurgeon's Perspective"**
John Tew, Jr, MD, Cincinnati, OH
10:50 AM **"The Physician's Image in the Nursing Home"**
James M. Turnbull, MD, Johnson City, TN
11:10 AM **"Benign Prostatic Hyperplasia: Is a TURP Still Necessary?"**
Joseph E. Oesterling, MD, Rochester, MN
11:30 AM **"Prevention: Focusing on Health"**
Joycelyn Elders, MD, Little Rock, AR

Ky Chapter American College of Chest Physicians

Meeting Room 104 — Lower Level —
Commonwealth Convention Center
Tuesday, September 15, 1992

- 1:30 PM **"Rationale for the Use of ACE Inhibitors in the Treatment of Patients with Mild Heart Failure Not Responding Adequately to Digitalis and Diuretics"**
Joseph D. Babb, MD, Bridgeport, CT
2:15 PM **"Current Controversies in COPD Management"**
David C. Levin, MD, Oklahoma City, OK
3:00 PM **Intermission to Visit Exhibits**
3:30 PM **"Management of Ventricular Arrhythmias in the 90s"**
Albert L. Waldo, MD, Cleveland, OH
4:15 PM **"Remodeling of the Heart: The Role of ACE Inhibition"**
Philip C. Kirlin, MD, Indianapolis, IN



KMA Medical Student Section & KMA Resident Physician Section

Meeting Rooms 110 & 111 — Lower Level —
Commonwealth Convention Center
Tuesday, September 15, 1992

- 1:00 PM Welcome — Presidents of the two Sections
- 1:10 PM Welcome from KMA
- 1:30 PM **"Humor in Medicine"**
Clifford Kuhn, MD, Louisville
- 1:50 PM **"How to Avoid Getting Sued"**
Randolph Starks
Kentucky Medical Insurance Company
- 2:40 PM Question & Answer Session
- 3:00 PM **Business Session**
Representatives of the AMA RPS and MSS and
KMA Section Governing Council officers

Ky Neurosurgical Society

Meeting Room 109 — Lower Level —
Commonwealth Convention Center
Tuesday, September 15, 1992

- 1:30 PM **"Recent Developments in the Management of
Arteriovenous Malformations"**
John Tew, Jr, MD, Cincinnati, OH
- 2:30 PM **Intermission to Visit Exhibits**
- 3:00 PM **"Experience with Intraoperative Somato-
Sensory Evoked Potentials"**
William C. Madauss, MD, Owensboro, KY
- 3:30 PM **"Experience with Intraoperative Motor Evoked
Potentials"**
George Raque, MD, Louisville, KY
- 4:00 PM **"Single Brain Metastasis"**
James Oexmann, MD, Owensboro, KY
- 4:30 PM **Business Meeting**

The Kentucky Medical Association is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

Ky OB/GYN Society — Ky Section — ACOG

Meeting Room 105 — Lower Level —
Commonwealth Convention Center
Tuesday, September 15, 1992

- 1:30 PM **"Prevention of Preterm Birth"**
Steven G. Gabbe, MD, Columbus, OH
- 2:00 PM **"The Use of Amnio-infusion in Obstetrics"**
Vernon D. Cook, Jr, MD, Louisville, KY
- 3:00 PM **"Advances in Diagnosis and Management of
Endometrial Adenocarcinoma"**
David L. Doering, MD, Louisville, KY
- 3:30 PM **Intermission to Visit Exhibits**
- 4:00 PM **"Pediatric/Adolescent Gynecology"**
Joseph Sanfilippo, MD, Louisville, KY
- 4:30 PM **"Contraception in the Woman Over 35 Years
of Age"**
Dwight D. Pridham, MD, Louisville, KY

Ky Chapter American College of Surgeons

General Sessions Area —
Commonwealth Convention Center
Tuesday, September 15, 1992

- 1:30 PM **"ERCP and Laparoscopic Cholecystectomy"**
William E. Strodel, MD, Lexington, KY
- 1:45 PM **"Restoring Intestinal Continuity Following
Operation For Inflammatory Bowel Disease"**
Susan Galandiuk, MD, Louisville, KY
- 2:00 PM **"Monoclonal Antibody Therapy"**
Steven Johnson, MD, Lexington, KY
- 2:15 PM **To Be Announced**
Tom R. DeMeester, MD, Los Angeles, CA
- 2:45 PM **Intermission to Visit Exhibits**
- 3:15 PM **"Lymphatic Complications Following Trauma"**
Frank B. Miller, MD, Louisville, KY
- 3:30 PM **"Management of Graft Infections"**
Thomas M. Bergamini, MD, Louisville, KY
- 3:45 PM **"Transesophageal Echo and Aortic Injury"**
Paul A. Kearney, MD, Lexington, KY
- 4:00 PM **"Hepatic Resection for Primary and Metastatic
Cancer"**
Michael J. Edwards, MD, Louisville, KY
- 4:15 PM **Business Meeting**
- 4:45 PM **Adjournment**

Ky Pediatric Society

Meeting Room 106 — Lower Level —
Commonwealth Convention Center
Tuesday, September 15, 1992

- 1:30 PM **"Adolescent Health: Can We Make a Difference?"**
Joycelyn Elders, MD, Little Rock, AR
- 2:15 PM **"Children's Health Issues"**
Panel Discussion — Robert Blair, MD, Frankfort, KY; Beverly M. Gaines, MD, Louisville, KY; Philip K. Lichtenstein, MD, Highland Heights, KY; and Sheila Woods, MD, Lexington, KY
- 2:45 PM **Intermission to Visit Exhibits**
- 3:15 PM **"The Lexington 'Healthy Tomorrows' Program"**
Doane Fischer, MD, Lexington, KY
- 3:45 PM **"Breaking the Cycle?"**
J. Thomas Badgett, MD, PhD, Louisville, KY
- 4:15 PM **Adjournment**

Ky Urological Association

Meeting Room 107 — Lower Level —
Commonwealth Convention Center
Tuesday, September 15, 1992

- 1:30 PM **"Prostate-Specific Antigen: Emerging Concepts in 1992"**
Joseph E. Oesterling, MD, Rochester, MN
- 2:00 PM **"Adult Urinary Tract Infection"**
Lloyd Harrison, MD, Winston-Salem, NC
- 2:30 PM **Intermission to Visit Exhibits**
- 3:00 PM **Pyelogram Hour**
- 4:00 PM **Annual Business Meeting**

Ky Psychiatric Association

Meeting Room 108 — Lower Level —
Commonwealth Convention Center
Tuesday, September 15, 1992

- 1:30 PM **"Keeping Sane in a Crazy World"**
James M. Turnbull, MD, Johnson City, TN
- 2:30 PM **Intermission to Visit Exhibits**
- 3:00 PM **"Litigation Lust"**
Linda S. Mangels, PhD, Longwood, FL

Sonia R. Teller, MD

**Chairperson
Scientific Program Committee
Presiding**

Wednesday, September 16, 1992
Morning General Session
General Sessions Area —
Commonwealth Convention Center

- 8:50 AM Announcements
- 9:00 AM **"The We Care Program — One Solution to the Problem of Indigent Health Care"**
E. Scott Medley, MD, Gainesville, FL
- 9:20 AM **"The Emergency Room — The Challenges of AIDS in its Second Decade"**
P. Samuel Pegram, Jr, MD, Winston-Salem, NC
- 9:40 AM **"The Risks of Transfusion"**
Linda Stehling, MD, Scottsdale, AZ
- 10:00 AM **Intermission to Visit Exhibits**
- 10:30 AM **"Epidemiologic Oversight of Medical Practices"**
Henry Krakauer, MD, PhD, Bethesda, MD
- 10:50 AM **"Quantifying the Risks of Silicone Breast Implants"**
Mary H. McGrath, MD, Washington, DC
- 11:10 AM **"Occupational Medicine: The Challenge for the Primary Care Physician"**
Thomas R. Hales, MD, Denver, CO
- 11:30 AM **"HIV Infection Among Patients in the Acute Health Care Setting: The Role of Routine HIV Counseling and Testing Services"**
John W. Ward, MD, Atlanta, GA
- 11:50 AM **PRESIDENT'S LUNCHEON**

**President's Installation & Awards
Luncheon**

Wednesday, September 16, 1992 -- 11:50 am

Regency Ballroom -- Hyatt Regency Hotel

S. Randolph Scheen, MD

KMA President, presiding

Invocation

Recognition

Awards Presentation

Nelson B. Rue, MD, Bowling Green

Chairman, KMA Awards Committee

Installation of new KMA President



Ky Chapter, American College of Emergency Physicians

Meeting Room 109 — Lower Level —
Commonwealth Convention Center
Wednesday, September 16, 1992

- 2:15 PM **"AIDS Risk in the Emergency Room"**
P. Samuel Pegram, Jr, MD, Winston-Salem, NC
- 3:15 PM **Intermission to Visit Exhibits**
- 3:30 PM **Questions & Answers**
P. Samuel Pegram, Jr, MD, Winston-Salem, NC
- 4:00 PM **Intermission to Visit Exhibits**
- 4:30 PM **Business Meeting**
- 5:30 PM **Adjournment**

Ky Chapter, American Academy of Family Physicians

Meeting Room 107 — Lower Level —
Commonwealth Convention Center
Wednesday, September 16, 1992

- 2:15 PM **"Mitral Valve Prolapse and the Family
Physician — When Things Don't Click"**
E. Scott Medley, MD, Gainesville, FL
- 3:30 PM **Intermission to Visit Exhibits**
- 4:00 PM **"A Method to Improve Patient Care Delivered
by Residents Based on Information Presented
in Lecture Format"**
Larry S. Fields, MD, Ashland, KY
- 5:00 PM **Adjournment**

Ky Occupational Medical Association

Meeting Room 106 — Lower Level —
Commonwealth Convention Center
Wednesday, September 16, 1992

- 2:15 PM **"The Role of the Federal Government in
Occupational Medicine"**
Thomas R. Hales, MD, Denver, CO
- 2:45 PM **"Understanding the Patient's Agenda as a
Source of Non-compliance"**
Richard K. Johnson, PhD, Louisville, KY
- 3:15 PM **Intermission to Visit Exhibits**
- 3:45 PM **"Acute and Chronic Myofascial Pain"**
Terry L. Davis, MD, Louisville, KY
- 4:15 PM **"Sixty Megaton Blast — A Living Witness"**
Ferrell C. Lowrey, Jr, MD, Louisville, KY
- 4:45 PM **Adjournment**

Ky Academy of Physical Medicine and Rehabilitation

Meeting Room 103 — Lower Level —
Commonwealth Convention Center
Wednesday, September 16, 1992

- 2:15 PM **Business Meeting**
- 3:00 PM **Intermission to Visit Exhibits**
- 3:15 PM **"Painful Compression of the Lateral
Antebrachial Cutaneous Nerve in C5-C6
Quadriplegia"**
James R. Farrage, Jr, MD, Lexington
- "Occipital Neuralgia Presenting as Myofascial
Pain Syndrome"**
Robert Lindsey, MD, Lexington
- "Restraint Use in Inpatient Rehab: Incidence,
Prevalence, and Implications"**
Susan McDowell, MD, Lexington
- "A Survey of Smoking and Drinking Habits in
Patients With Spinal Cord Injury"**
Milagros Arroyo, MD, Louisville
- "Self-Care Knowledge of Lower Extremity
Amputees"**
Holmes Marchman, MD, Louisville
- "Correlation of Foot Arch Size and
Osteoarthritis of the Lower Extremity"**
Louie Williams, MD, Louisville
- 4:00 PM **"Injection Techniques & Treatment of
Stasticity"**
Essam A. Awad, MD, PhD, Minneapolis, MN

Ky Chapter American College of Physicians

Meeting Room 108 — Lower Level —
Commonwealth Convention Center
Wednesday, September 16, 1992

- 2:15 PM **"Continuation of Computers in Medicine"**
Henry Krakauer, MD, Bethesda, MD
- 3:00 PM **"Washington Update"**
ACP Representative
- 3:30 PM **Intermission to Visit Exhibits**
- 4:00 PM **"Associates Program"**
Harry W. Carlross, MD, Paducah, KY
- 4:15 PM **University of Louisville**
Daniel W. Varga, MD, Louisville, KY
- 4:45 PM **University of Kentucky**
John V. Borders, MD, Lexington, KY

Ky Society for Plastic & Reconstructive Surgery

General Sessions Area —
Commonwealth Convention Center
Wednesday, September 16, 1992

- 2:15 PM To Be Announced
Anne L. Edwards, MD, Lexington, KY
- 2:25 PM **"Soft Tissue Management of GSWs to the Trunk"**
Steven F. Lay, MD, Louisville, KY
- 2:35 PM To Be Announced
William F. Kivett, MD, Lexington, KY
- 2:45 PM To Be Announced
Al Rosenthal, MD, Louisville, KY
- 2:55 PM Discussion
- 3:15 PM **Intermission to Visit Exhibits**
- 3:45 PM **"Marketing Plastic Surgery: Does it Accomplish its Purpose?"**
Mary H. McGrath, MD, Washington, DC
- 5:00 PM Business Meeting

Ky Association of Public Health Physicians

Meeting Room 104 — Lower Level —
Commonwealth Convention Center
Wednesday, September 16, 1992

- 2:15 PM **"Prevention of HIV Transmission in the Health Care Setting: The Role of HIV Testing"**
John W. Ward, MD, Atlanta, GA
- 3:30 PM **Intermission to Visit Exhibits**
- 4:00 PM Business Meeting
- 5:00 PM Adjournment

Ky Society of Pathologists

Meeting Room 105 — Lower Level —
Commonwealth Convention Center
Wednesday, September 16, 1992

- 2:15 PM **"Will We Ever Have Risk Free Blood?"**
Linda Stehling, MD, Scottsdale, AZ
- 3:15 PM **Intermission to Visit Exhibits**
- 3:45 PM Business Meeting

Ardis D. Hoven, MD KMA Vice President, Presiding

Thursday, September 17, 1992
Morning General Session
General Sessions Area —
Commonwealth Convention Center

- 8:50 AM Announcements
- 9:00 AM **"Risk for Dementia Induced By Drugs"**
David Lowenthal, MD, PhD, Gainesville, FL
- 9:20 AM **"Immunotherapy in the 21st Century: Risks and Benefits for the Allergic Patient"**
John W. Georgitis, MD, Winston-Salem, NC
- 9:40 AM **"The Skin as a Window: Important Cutaneous Signs of Selected Systemic Diseases"**
Theodore Rosen, MD, Houston, TX
- 10:00 AM **"Skin and Eye"**
R. Doyle Stulting, MD, PhD, Atlanta, GA
- 10:20 AM **Intermission to Visit Exhibits**
- 10:50 AM **"Evaluation and Treatment of the Painful Shoulder: A Changing Spectrum of Disease with Age"**
Robert H. Cofield, MD, Rochester, MN
- 11:10 AM **"Endoscopic Ultrasound: Is it Useful for Staging Gastrointestinal Malignancy?"**
Marc L. Eckhauser, MD, Cleveland, OH
- 11:30 AM **"Referring Common Pain Problems"**
William S. Blau, MD, Chapel Hill, NC
- 11:50 AM **"Dizziness After Head Trauma"**
Allan Rubin, MD, PhD, Toledo, OH

Ky Society of Allergy & Clinical Immunology

Meeting Room 109 — Lower Level —
Commonwealth Convention Center
Thursday, September 17, 1992

- 1:00 PM **"Immunotherapy in the 21st Century: Risks and Benefits for the Allergic Patient"**
John W. Georgitis, MD, Winston-Salem, NC
- 2:00 PM **Intermission to Visit Exhibits**
- 2:30 PM **"Comparison of X-rays and C-T Examinations in Chronic Sinusitis in Children"**
Daniel P. Garcia, MD, Louisville, KY
- 3:30 PM **"Steroids and School Performance in Asthmatic Children"**
Mark L. Corbett, MD, Louisville, KY



Ky Society of Anesthesiologists

Meeting Room 106 — Lower Level —
Commonwealth Convention Center
Thursday, September 17, 1992

- 1:30 PM **"Comprehensive Pain Management: Strategies for the 1990s"**
William S. Blau, MD, Chapel Hill, NC
- 2:15 PM **"The Recent Advances in OB Anesthesia"**
Gary E. Loyd, MD, Louisville, KY
- 3:00 PM **Intermission to Visit Exhibits**
- 3:30 PM **"The Value and Limitations of Pulse Oximetry, Capnography & ECG Monitoring"**
Eugene A. Hessel, MD, Lexington, KY
- 4:15 PM **"New Approaches on the Management of Difficult Airway in Children"**
Steve M. Audenaert, MD, Louisville, KY
- 5:00 PM **"Medical Liability From an Anesthesiologist's Perspective"**
Elaine M. Bukowski, MD, Louisville, KY
- 5:45 PM **Adjournment**

Ky Dermatological Society

310 East Broadway
Louisville, KY
Thursday, September 17, 1992

- 1:30 PM **Case Presentations & Case Discussions**
- 3:00 PM **"The Relationship Between HIV Infection and Classical Sexually Transmissible Diseases"**
Theodore Rosen, MD, Houston, TX
- 4:00 PM **Business Meeting**
- 5:00 PM **Adjournment**

Ky Society of Otolaryngology — Head & Neck Surgery, Inc

Department of Otolaryngology
University of Louisville, Louisville, KY
Thursday, September 17, 1992

- 1:30 PM **"Dizziness and Environmental Toxins"**
Allan M. Rubin, MD, PhD, Toledo, OH
- 2:30 PM **Case Discussions**

Ky Academy of Eye Physicians & Surgeons

Meeting Room 108 — Lower Level —
Commonwealth Convention Center
Thursday, September 17, 1992

- 1:30 PM **"Herpetic Keratitis: Pitfalls, Problems & Promises"**
R. Doyle Stulting, MD, PhD, Atlanta, GA
- 2:15 PM **"Update on the Excimer Laser"**
Richard A. Eiferman, MD, Louisville, KY
- 2:40 PM **Intermission to Visit Exhibits**
- 3:00 PM **"The Red Eye and Contact Lenses"**
R. Doyle Stulting, MD, PhD, Atlanta, GA
- 3:45 PM **"Third Party Update"**
M. Douglas Gossman, MD, Crestwood, KY
- 4:00 PM **Questions and Answers**
- 4:30 PM **KAEPS Business Meeting**
- 5:00 PM **Cocktail Party — Gulfstream/Hialeah Rooms — 1st Floor, Hyatt**

Ky Society for Gastrointestinal Endoscopy

Meeting Room 105 — Lower Level —
Commonwealth Convention Center
Thursday, September 17, 1992

- 1:30 PM **"Endoscopic Ultrasound — Update"**
Nicholas J. Nickl, MD, Lexington, KY
- 1:45 PM **"Impact of Sphincter of Oddi Motility on the Management of Post-Cholecystectomy Abdominal Pain"**
Alan J. Cox, MD, Louisville, KY
- 2:00 PM **"Laparoscopic Cholecystectomy and Choledocholithiasis"**
Thomas N. Zweng, MD, Lexington, KY
- 2:15 PM **"Laser Ablation of GI Neoplasms"**
Marc L. Eckhauser, MD, Cleveland, OH
- 2:45 PM **Intermission to Visit Exhibits**
- 3:15 PM **"Beano Doesn't Work"**
Thomas H. Rupp, MD, Louisville, KY
- 3:30 PM **"Stress Gastritis Prevention and Treatment"**
David Lipski, MD, Louisville, KY
- 3:45 PM **"Transesophageal Echo and Aortic Injury"**
Paul A. Kearney, MD, Lexington, KY
- 4:00 PM **Business Meeting**
- 4:30 PM **Adjournment**

Ky Geriatrics Society

Meeting Room 110 — Lower Level —
Commonwealth Convention Center
Thursday, September 17, 1992

- 1:30 PM **Does Exercise Slow or Reverse the Aging Process?"**
David Lowenthal, MD, PhD, Gainesville, FL
- 2:30 PM **"The Evaluation and Treatment of Men with Asymptomatic Prostate Nodules in Primary Care"**
James W. Mold, MD, Louisville, KY
- 3:00 PM **Intermission to Visit Exhibits**
- 3:15 PM **"Helping Your Patients Attain Serenity"**
Kay T. Roberts, EdD, RN, C, Louisville, KY
- 3:45 PM **"Syphilis in the Elderly"**
Kenneth E. Holtzapple, MD, Louisville, KY
- 4:15 PM **Business Meeting**
- 5:15 PM **Adjournment**

Ky Orthopaedic Society

Meeting Room 107 — Lower Level —
Commonwealth Convention Center
Thursday, September 17, 1992

- 1:30 PM **"Proximal Femoral Replacement for Metastatic Disease"**
Jeffrey W. Parr, MD, and Eugene Q. Parr, MD, Lexington, KY
- 1:50 PM **"Lisfranc Fracture and Compartment Syndrome of the Foot"**
George E. Quill, Jr, MD, Louisville, KY
- 2:10 PM **"Surgery for Idiopathic Scoliosis"**
Richard D. Holt, MD, Louisville, KY
- 2:30 PM **Intermission to Visit Exhibits**
- 3:00 PM **"Surgical Treatment for Shoulder Arthritis"**
Robert Cofield, MD, Rochester, MN
- 3:40 PM **"Appearance of the Median Nerve During Carpal Tunnel Release: Reliability of the Surgeon's Grading"**
Steven J. McCabe, MD, Louisville, KY
- 4:00 PM **To Be Announced**
- 4:30 PM **Business Meeting**

**CONTINUING
MEDICAL
EDUCATION**

The Kentucky Medical Association designates this continuing medical education activity for 17.0 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association. One credit hour may be claimed for each hour of participation by the individual physician.

"Be our Guest"

*If you are a physician age 40 years or younger, or
if you've been in practice 5 years or less...*

*Be our guest and join your colleagues at a
luncheon being held during KMA's Annual Meeting*

Tuesday, September 15, 1992

12:00 noon

Keeneland Suite - Hyatt Regency Louisville

Speaker - Joy Maxey, MD, Chair-Elect, AMA-YPS

To reserve a lunch, please call (502) 426-6200

(Spouses welcome)

Make plans to attend!



General Sessions Learning Objectives

Immunotherapy in the 21st Century: Risks and Benefits for the Allergic Patient

John W. Georgitis, MD

Immunotherapy has been utilized since 1910 in the treatment of allergic disorders. The immunologic basis is to counteract the IgE-allergen binding on the surface of the mast cell, thereby inhibiting the allergic response. The risk of anaphylaxis is great for highly atopic individuals. The efficacy of immunotherapy for allergic rhinitis is well established, whereas for asthma, it still warrants investigation. Use of modified allergens has presented great expectations for the practicing allergist by reducing the risks of anaphylaxis while maintaining clinical efficacy of the immunotherapy. The purpose of the presentation is:

1. To summarize the immunologic basis of immunotherapy to date;
2. To review use of modified allergens for immunotherapy; and
3. To project the changes in immunotherapy for the future in regards to alternative modes of delivery and treatment schedules.

The Skin as a Window: Important Cutaneous Signs of Selected Systemic Diseases

Theodore Rosen, MD

1. To recognize salient and critical cutaneous signs for four selected multisystem diseases;
2. To appreciate the necessity for referral for dermatological consultation in selected cases/presentations;
3. To understand the pathophysiology of cutaneous signs of selected multisystem diseases; and
4. To appreciate the risk, both to the patient and to the physician, of failing to consider skin signs of systemic disease.

The We Care Program — One Solution to the Problem of Indigent Health Care

E. Scott Medley, MD

1. To learn how a county medical society worked with local government to set up an indigent care program;
2. To learn how this indigent care program was presented to physicians so as to gain their cooperation with it; and
3. To learn how the program increases ac-

cess to hospital and subspecialty care for indigent patients.

Screening for Gestational Diabetes Mellitus

Steven G. Gabbe, MD

1. To describe the metabolic changes in pregnancy which produce a "diabetogenic stress"; and
2. To discuss the need to detect gestational diabetes in pregnancy, and methods presently in use for such testing.

Occupational Medicine: The Challenge for the Primary Care Physician

Thomas R. Hales, MD

Given the shortage of occupational medicine physicians, many employers rely on primary care physicians, particularly internists, to treat their injured employees. Treating injured and ill workers is one of many responsibilities for occupational medicine physicians.

To outline many of the other responsibilities for physicians who treat industrial workers.

The Risks of Transfusion

Linda Stehling, MD

To familiarize the attendees with the current estimated risks of transfusion-transmitted disease and other complications of transfusion.

Epidemiologic Oversight of Medical Practices

Henry Krakauer, MD, PhD

1. To provide an understanding of the epidemiologic techniques for the analysis of the patients and their burden of disease, the patterns of the care to which they are subjected, and the outcomes they experience;
2. To identify the strategies that have the highest probability of benefiting the patients by evaluating the associations between the patterns of care and the patterns of outcomes;
3. To develop techniques for the feed-back of the results of the analyses to assist clinicians and patients in arriving at informed decisions on the choice of therapies; and
4. To describe the infrastructure that will

support the ongoing application of these methodologies for the continuing improvement of medical practice.

Dizziness After Head Trauma

Allan M. Rubin, MD, PhD

1. To be able to appreciate the symptoms that patients complain of who had sustained head injury.
2. To be able to appreciate the techniques used to evaluate these patients.
3. To be able to appreciate the techniques used to treat these patients.

Endoscopic Ultrasound: Is it Useful for Staging Gastrointestinal Malignancy?

Marc L. Eckhauser, MD

1. To be able to understand the concept of transintestinal ultrasound.
2. To be able to recognize the benefits obtained by more accurately staging gastrointestinal malignancies preoperatively.

Problems and Solutions in the Management of Congestive Heart Failure

Joseph D. Babb, MD

1. To review results of recent clinical trials.
2. To develop a pathophysiologic framework for clinical management.

Evaluation and Treatment of the Painful Shoulder: A Changing Spectrum of Disease with Age

Robert H. Cofield, MD

1. To become familiar with currently available imaging procedures, their benefits and their limitations;
2. To understand the role and benefit of conservative treatment modalities;
3. To know the current surgical treatment options for shoulder disorders; and
4. To understand the anticipated outcomes of treatment for shoulder disorders, be it operative or nonoperative.

Prevention: Focusing on Health

M. Joycelyn Elders, MD

To discuss those things which can be done to improve health status as opposed to paying for dying, and the importance of preventive health care and what health care providers can do to make a difference.

HIV Infection Among Patients in the Acute Health Care Setting: The Role of Routine HIV Counseling and Testing Services

John W. Ward, MD

To understand the data regarding:

1. The rate of HIV infection among hospitalized patients;
2. The risk of HIV transmission in the acute health care setting;
3. The potential benefits and risks of HIV counseling and testing for the patient;
4. The potential benefits and risks of HIV counseling and testing for the health care provider; and
5. Possible strategies to target routine HIV counseling and testing services in the acute health care setting.

Referring Common Pain Problems

William S. Blau, MD

1. To know the indications/risks of narcotic use for acute and chronic pain;
2. To be able to identify patients who require referral to a pain specialist; and
3. To understand how to refer to a pain specialist.

The Skin and the Eye

R. Doyle Stulting, MD, PhD

To discuss ocular and dermatologic manifestations of selected diseases and the ocular complications of some dermatologic treatments.

Quantifying the Risks of Silicone Breast Implants

Mary H. McGrath, MD

1. To review the medical concerns about the safety of silicone breast implants;
2. To look at evidence for a link between the development of connective tissue disease and the presence of silicone devices in the body;
3. To look at the incidence of breast cancer in women with silicone breast implants; and
4. To review mammographic efficacy in the breast with a silicone implant; to review the technical features of mammography in the woman with breast implants.

Benign Prostatic Hyperplasia: Is a TURP Still Necessary?

Joseph E. Oesterling, MD

1. To review the etiology and prevalence of benign prostatic hyperplasia;

2. To discuss the results of outcome research with regard to the gold standard treatment, transurethral resection of the prostate;
3. To review the medical therapies currently under investigation for symptomatic benign prostatic hyperplasia; and
4. To summarize the minimally invasive procedures that are being developed as alternative treatments to TURP for patients with symptomatic benign prostatic hyperplasia.

The Emergency Room — The Challenges of AIDS in its Second Decade

P. Samuel Pegram, Jr, MD

1. To gain an understanding of the spectrum of clinical HIV disease;
2. To discuss the implications of testing patients and health care workers; and
3. To discuss the approach to diagnosis and treatment of HIV-related phenomena.

The Physician's Image in the Nursing Home

James M. Turnbull, MD

1. To discuss the unique role physicians play in the improvement of care of the elderly in nursing homes.
2. To discuss how through active involvement, the support of other staff, an openness to the patients and an optimistic attitude, the physician can contribute greatly to the quality of life of these people and, in the process, fulfill a professional obligation to continuity of care.

Risk for Dementia Induced by Drugs

David Lowenthal, MD, PhD

1. To learn the varied ways of disease presentation in the elderly.
2. To learn that drug therapy in the elderly can mimic disease.
3. To differentiate between dementia and delirium.
4. To understand the concept of adverse drug reactions.

New Technology to Aid Risk Reduction in Surgery: A Neurosurgeon's Perspective

John Tew, MD

The participants will understand new technical developments in neurological diagnosis and treatment that improve quality and reduce risk of adverse reactions.

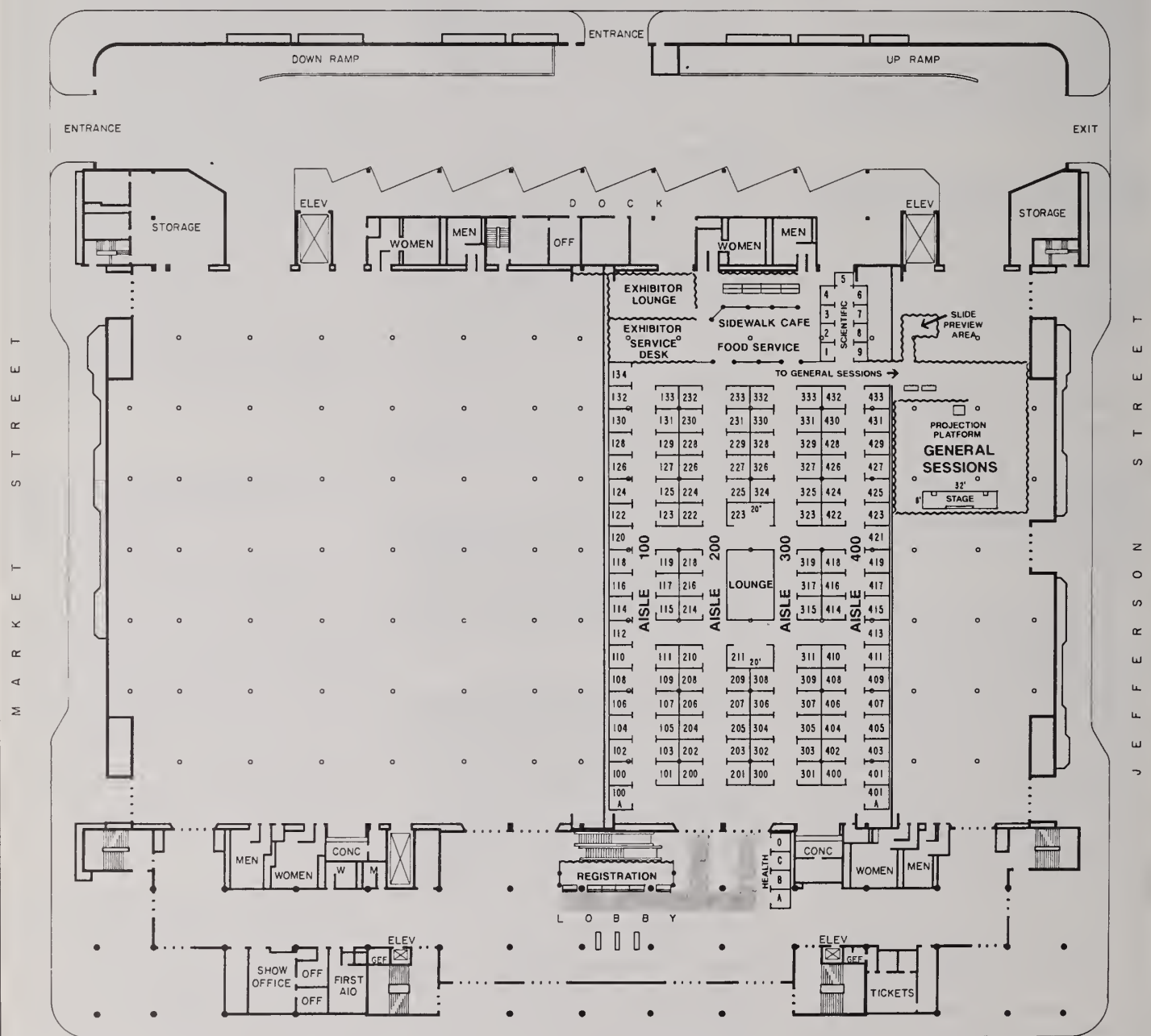


EXHIBIT HALL FLOOR PLAN

COMMONWEALTH CONVENTION CENTER

LOUISVILLE, KENTUCKY

T H I R D S T R E E T



All exhibitors with corresponding booth space(s) are listed on this map of the Exhibit Hall. We regret that due to printing and publication deadlines, not all exhibitors are represented in this Exhibit Guide. For more detailed information on the exhibitors, refer to the Technical Exhibits listing beginning on page 426, and please visit them in the Exhibit Hall.



EXHIBITOR DIRECTORY

- Abbott Laboratories
#201 & 301
- Administrative Resources, Inc
#227
- Berlex Laboratories
#300
- Blue Cross and Blue Shield of Kentucky
#216
- Boehringer Ingelheim Pharmaceuticals
#409
- Boots Pharmaceuticals
#114
- Bristol Laboratories
#309
- Burroughs Wellcome Company
#319
- Cardinal Hill Rehabilitation Hospital
#423
- Carnrick Laboratories
#108
- Central Pharmaceuticals, Inc
#303
- Charter Hospitals of Kentucky
#431
- Ciba Pharmaceuticals
#218
- Clayton L. Scroggins Associates, Inc
#421
- Clinical Pathology Associates
#118 & 120
- CVC Mobile Diagnostics
#230
- Daniels Pharmaceuticals, Inc
#429
- Dawson-Weber Medical
#123
- Disability Determinations
#430
- Dista Products Company
#400
- Dodson Group
#405
- Eli Lilly and Company
#315
- Fisons Pharmaceuticals
#333
- Geigy Pharmaceutical Company
#131
- General Medical Corp
#307
- Glaxo Pharmaceuticals
#111
- Greater Louisville Coalition of PAs/NPs
#329
- Greentree Applied Systems, Inc
#112
- Grogan's Healthcare Supply
#325
- HealthNet IV/St Joseph Hospital
#206
- Humana, Inc
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- ICI Pharma/Stuart Pharmaceuticals
#331
- Image Technology, Inc
#304
- Insurance Corp of America
#232
- Janssen Pharmaceutica
#302
- Jewish Hospital HealthCare Services
#100
- Kentucky Air National Guard
#330
- Kentucky Army National Guard
#402
- Kentucky Beef Council
#428
- Kentucky Medical Insurance Co
#223
- Kentucky Medical Review Organization
#133
- Kentucky Organ Donor Affiliates
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- Kentucky Telco FCU
#100A
- Key Pharmaceuticals
#305
- Kimberly Quality Care
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- Knoll Pharmaceuticals
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- Lakeview Rehabilitation Hospital
#209
- Lederle Laboratories
#214
- Marion Merrell Dow, Inc
#410
- Marquette Electronics, Inc
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- McNeil Consumer Products
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- MD Systems
#424
- Mead Johnson Nutritionals
#323
- Mead Johnson Pharmaceuticals
#317
- Medic Computer Systems
#403
- Medical Management Resources, Inc
#101
- The Medical Protective Company
#211
- Medical Technology Corporation
#327
- Merck Human Health Division
#226
- Metropolitan Reference Laboratories, Inc
#411
- Norton Psychiatric Clinic
#224
- Olsten HealthCare
#425
- Olympus Corp
#306
- OPTION Care
#105
- Ortho Pharmaceutical
#416
- Our Lady of Peace Hospital
#413
- Parke-Davis
#210
- Pfizer Laboratories
#233
- Physicians Sales & Service
#109
- The PIE Mutual Insurance Company
#422
- Pratt Pharmaceuticals
#207
- Procter & Gamble Pharmaceuticals
#326
- Professional Data Control
#130
- Professionals' Purchasing Group
#408
- RANAC Computer Corporation
#225
- Ransdell Surgical, Inc
#115
- Reed & Carnrick Pharmaceuticals
#203
- Republic Bank & Trust Co
#427
- Roche Biomedical Laboratories
#332
- Roerig Pharmaceuticals
#433
- Ross Laboratories
#200
- Saint Joseph Hospital
#204
- Salcris Systems
#231
- Sandoz Pharmaceuticals
#222
- Sanofi-Winthrop Pharmaceuticals
#103
- Savage Laboratories
#415
- Searle
#311
- Shearson Lehman Brothers, Inc
#324
- SKYCARE
#102
- SmithKline Beecham Clinical Laboratories
#119
- SmithKline Beecham Pharmaceuticals
#407
- Southeastern Data Systems
#106
- SpectraCare, Inc
#205
- Squibb US Pharmaceutical Group
#104
- Summit Pharmaceuticals
#419
- 3M Pharmaceuticals
#404
- UNICO, Inc.
#122
- United States Air Force
#134
- United States Army Medical Department
#414
- University of Kentucky Hospital Chandler Medical Center
#417
- The Upjohn Company
#432
- VersaCom, Inc
#328
- Whitby Pharmaceuticals, Inc
#418
- Wisner* Martin
#202
- Wyeth-Ayerst/A.H. Robins
#401 & 401A
- Wyeth Laboratories
#426

EXHIBIT GUIDE

1992



TECHNICAL EXHIBITS

Plan to visit the Exhibit Hall during the 1992 KMA Annual Meeting. Trained professional representatives of more than 120 firms will be on hand to discuss with you the details of their products and services in a relaxed atmosphere — with no patients waiting in your outer office and with no telephones ringing.

Located in the Commonwealth Convention Center, the exhibits will condense a volume of information and ideas in such a manner that a vast amount of knowledge can be secured in a short period of time.

The Exhibit Hall is an important part of the Annual Meeting and is the site of registration for all CME courses.

Thirty-minute intermissions have been planned during each general and specialty group session so that every physician may take advantage of this opportunity to benefit their practice and their patients.

Abbott Laboratories #201 & 301

One Abbott Park Road
Abbott Park, IL 60064-3500
(708) 937-7141

Administrative Resources, Inc #227

1500 Newtown Pike, Suite W
Lexington, KY 40511
(606) 259-2882

Berlex Laboratories #300

300 Fairfield Road
Wayne, NJ 07470
(201) 305-5082

Blue Cross and Blue Shield of Kentucky #216

9901 Linn Station Road
Louisville, KY 40223
(502) 423-2150
Provider Relations representatives will be available during the exhibit with information about Blue Cross and Blue Shield of Kentucky programs.

Boehringer Ingelheim Pharmaceuticals #409

900 Ridgebury Road
Ridgefield, CT 06877-0368
(203) 798-9988

Bristol Laboratories #309

Evansville, IN 47721-0001
(812) 429-5000
We cordially invite you to visit our exhibit to meet our representatives who welcome the opportunity to discuss products and services of interest to you. Featured will be Cefzil (cefprozil); Corgard (nadolol tablets); Questran Light (cholestyramine for oral suspension).

Burroughs Wellcome Company #319

3030 Cornwallis Road
Research Triangle Park, NC 27709
(919) 248-3000

Cardinal Hill Rehabilitation Hospital #423

2050 Versailles Road
Lexington, KY 40504
(606) 254-5701, Ext 511

Located in Lexington, Kentucky, Cardinal Hill Rehabilitation Hospital provides physical rehabilitation services to people of all ages. Physiatrists, nurses, physical and occupational therapists, speech language pathologists, psychologists, social service professionals, dieticians, and recreation therapists work as a team using individual case managers to meet the needs of our patients and their families. Inpatient programs include head injury, stroke, spinal cord, general rehabilitation, and extended rehabilitation for longer term care of the head injured patient. Outpatient programs include a rehabilitation clinic, outpatient therapy services, the pain management center, the occupational medicine center, and the continence treatment diagnostic service.

Carrick Laboratories #108

65 Horse Hill Road
Cedar Knolls, NJ 07927
(201) 267-2670

Central Pharmaceuticals, Inc #303

120 East Third St
Seymour, IN 47274
(812) 522-3915

Charter Hospitals of Kentucky #431

3050 Rio Dosa Dr
Lexington, KY 40509
(606) 269-2325 or 1-800-753-HOPE
Charter Medical Corporation operates three facilities in Kentucky which offer inpatient psychiatric and addictive disease programs for children, adolescents, and adults. Our facilities in Lexington and Louisville also offer

outpatient services, with the facility in Paducah offering a residential treatment program for adolescents. Each facility offers free screenings, with our Needs Assessment and Referral Centers open seven days a week, 24 hours a day.

Ciba Pharmaceuticals #218

5587 Dove Lane
West Chester, OH 45069
(513) 779-9116

Clayton L Scroggins Associates, Inc #421

200 Northland Blvd
Cincinnati, OH 45246
(513) 771-7070

For nearly 50 years Scroggins Associates has provided financial and practice management consulting services to physicians exclusively, helping them run their practices more smoothly and efficiently. Impartial counsel in a professional, comprehensive and confidential manner on a fee for service basis. Services throughout Kentucky, Ohio, and Indiana.

Clinical Pathology Associates #118 & 120

6400 Dutchmans Parkway, Suite 40
Louisville, KY 40205
(502) 897-9594

Clinical Pathology Associates (CPA) offers a full range of clinical and anatomic laboratory services as well as comprehensive billing services and experienced consulting services for compliance with OSHA and CLIA '88 regulations. CPA's laboratory offers pap and tissue interpretation as well as "STAT" bloodwork analyses. CPA's billing service offers electronic insurance claims filing and office terminal hook-ups. CPA's Physician Office Advisor will



work with your office staff to meet all existing government regulations.

CVC Mobile Diagnostics #230
6400 Dutchmans Pky, Suite 335
Louisville, KY 40205
(502) 894-8426

Mobile ultrasound company provides mobile ultrasound to many medical communities in Kentucky and Indiana. Equipment is brought into the medical facility (office, hospital, clinic); the procedures are performed and a preliminary report is left with the physician and a final report is sent to the referring physician within 12 hours. Services available: Echocardiography M-mode, 2D, Doppler, Color Flow Tee, Stress Echo. Cardiovascular: Carotid U/S, Lower Extremity U/S, Segmental Pressure (Lower Extremity).

Daniels Pharmaceuticals, Inc #429
2517 25th Avenue N
St. Petersburg, FL 33713
1-800-237-7427

Daniels Pharmaceuticals' Levoxine® (Levothyroxine Sodium Tablets, USP) is a brand name product available in 11-color-coded strengths for consistent quality thyroid replacement therapy. Levoxine has shown to be clinically equivalent with leading brands at a 50% or more cost saving to the patient.

Dawson-Weber Medical #123
2100 Gardiner Lane, Suite 216A
Louisville, KY 40205
(502) 451-6272

Holter Monitors, Spirometers, Blood Testing Equipment featuring the Hemocue System for Lab Quality measurement of Glucose and Hemoglobin on a "stat" basis.

Disability Determinations #430
PO Box 1000
Frankfort, KY 40601

Dista Products Company #400
Lilly Corporate Center
Indianapolis, IN 46285
(317) 276-2554

You are cordially invited to visit the

Dista Products Company exhibit. Our sales representative in attendance will welcome your questions about our pharmaceutical products including Prozac® (fluoxetine hydrochloride, Dista), Axid™ (nizatidine, Lilly), and Ceclor® (cefaclor, Lilly).

Dodson Group #405
9201 State Line
Kansas City, MO 64114
1-800-825-3760

Dividend program for Workers' Compensation Insurance approved by the Kentucky Medical Association since 1985.

Eli Lilly and Company #315
Lilly Corporate Center
Indianapolis, IN 46285
(317) 276-2554

Eli Lilly and Company welcomes the opportunity to support your organization through participation in your exhibit program. We cordially invite you to visit our display and discuss any inquiries you may have concerning Ceclor® (cefaclor, Lilly), Axid™ (nizatidine, Lilly), and Humulin® (human insulin of recombinant DNA origin, Lilly).

Fisons Pharmaceuticals #333
9013 Bingham Dr
Louisville, KY 40242
(502) 425-6352

Fisons is a world leader in asthma and allergy research. Included among its products are the cromolyn sodium line which include: Intal, Nasalcrom, Opticrom, and Gastrocrom. Intal was one of the two anti-inflammatory agents listed by the National Heart, Lung, and Blood Institute for the treatment and control of chronic asthma. In addition, Fisons is soon to release a new anti-asthma product which is sure to revolutionize the way we treat asthma. For more information please stop by the Fisons booth.

Geigy Pharmaceutical Company #131
100 Campos Dr, Suite 320
Florham Park, NJ 07932
(201) 301-0700

General Medical Corporation #307
11112 Decimal Dr
Louisville, KY 40299
(502) 267-0311

Glaxo Pharmaceuticals #111
8601 Six Forks Road, Suite 610
Raleigh, NC 27615
(919) 848-6158

**Greater Louisville Coalition of Physician Assistants/
Nurse Practitioners #329**
6205 Glen Hill Road
Louisville, KY 40222
(502) 425-5988

Greentree Applied Systems, Inc #112
629 N Broadway
Lexington, KY 40508
(606) 254-6388

The Medistar-90 computer system was designed in Kentucky in 1990 specifically for Kentucky medical practices. We provide electronic claims submission directly to Medicare, Medicaid, and Blue Shield. You do not pay a per claim fee. Reasonable annual support fees, multiple equipment platforms, HMO support, fast patient lookup and data entry, custom modifications, appointment scheduling, telephone collections and a bad debt subsystem are a few of our outstanding features. Comprehensive after-sale training and support are provided from Lexington.

Grogan's Healthcare Supply #325
1016 S Broadway
Lexington, KY 40504
(606) 254-6661

Join us in the Grogan's booth for a close look at the latest innovations in exam room furniture and diagnostic equipment from Midmark, Ritter, and Welch Allyn, with exhibits changing daily.

HealthNet IV #206
St Joseph Hospital
One Saint Joseph Dr
Lexington, KY 40504
(606) 278-9811
HealthNet IV is St Joseph Hospital's air medical transport program. HealthNet

EXHIBIT GUIDE

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IV provides advanced life support helicopter transport for critically ill and injured patients requiring interfacility transfer to tertiary care, or transport from the scene of an accident or medical emergency. Staff members will be available to provide service materials and to answer your questions about air medical transport.

Humana, Inc #308

500 W Main St
Louisville, KY 40201-1438
(502) 580-1000

Humana, based in Louisville, is an integrated health care company operating 79 hospitals in the U.S. and abroad and offers a variety of health insurance plans for employee and Medicare beneficiaries. Stop by our booth and discuss practice opportunities in our Kentucky communities of Louisville, Lexington, Louisa, and Somerset.

ICI Pharma/Stuart Pharmaceuticals #331

Wilmington, DE 19897
1-800-441-7758

Image Technology, Inc #304

141 Prosperous Place #22B
Lexington, KY 40509
(606) 263-7777

PARADIGM Medical Management Software, offered by Image Technology, Inc, is a comprehensive data processing solution for medical billing, accounting, patient tracking, and practice management. PARADIGM uses the latest data base technology to provide the user with the speed and power required by today's large data bases. At the same time, PARADIGM is very easy to learn and use. Since PARADIGM was developed on an AT&T 3B2-500 mini computer with the UNIX operating system, it runs on all hardware platforms from the 386 and 486 computers through mini computers and mainframes. This portability provides the end user with investment protection for his software and peripherals, while providing nearly unlimited growth potential.

Insurance Corporation of America #232

4295 San Felipe, Suite 300
Houston, TX 77256-6308
(713) 871-8100

ICA markets professional liability insurance to physicians and surgeons nationwide through the independent agency system.

Janssen Pharmaceutica #302

40 Kingsbridge Road
Piscataway, NJ 08854
(908) 524-9249

Janssen — Leaders in allergy and dermatology.

Jewish Hospital HealthCare Services #100

217 E Chestnut St
Louisville, KY 40202
(502) 587-4914

Physicians in private practice are facing a radically different health care environment with ever increasing competition for patients. Jewish Hospital offers a comprehensive program to help physicians build their private practice and manage it more effectively. Some of the services provided to our physicians include associate recruitment, practice management services, community education and involvement, office staff seminars, market surveys, and patient communications. Information will be available describing recruitment enhancement programs.

Kentucky Air National Guard #330

Standiford Field
Louisville, KY 40213-2678
(502) 367-6721

The Kentucky Air Guard is a reserve component of the Air Force. It offers physicians and other medical professionals the opportunity to serve their state and nation in a unique way. Many doctors train to be flight surgeons which gives them opportunities no other part-time career can. You also receive good pay, benefits, retirement, and other valuable training that will enhance your career now.

Kentucky Army National Guard #402

Boone National Guard Center
Frankfort, KY 40601
(502) 564-8575

Kentucky Beef Council #428

733 Red Mile Road
Lexington, KY 40504
(606) 233-3722

Kentucky Beef Council will provide a wide variety of nutrition and health information materials for professionals. You will also be able to see patient education programs to use with patients who need to control the fat and cholesterol in their diets.

Kentucky Medical Insurance Company #223

Forum Two, Suite 200
303 N Hurstbourne Parkway
Louisville, KY 40222-5143
(502) 399-5700

Kentucky Medical Insurance Company, an AM Best A-(excellent) rated professional liability company, was created by the Kentucky Medical Association to insure and protect Kentucky physicians. Our Board of Directors is comprised of ten Kentucky physicians, the Executive Vice President of the Kentucky Medical Association and Kentucky Medical's CEO. We welcome the opportunity to discuss with you the superior benefits of being insured by Kentucky Medical.

Kentucky Medical Review Organization #133

10503 Timberwood Circle
PO Box 23540
Louisville, KY 40223
(502) 339-7442

Kentucky Medical Review Organization is a Peer Review Organization (PRO) that contracts with the federal government to provide medical peer review services for the Medicare program in Kentucky. The duties of the PRO are to ensure that the medical care provided to Medicare beneficiaries is reasonable and necessary, is provided in the appropriate setting, and meets the standards of quality accepted by the medical profession.



Kentucky Organ Donor Affiliates #228

305 W Broadway, Suite 316
Louisville, KY 40202
(502) 581-9511

Kentucky Organ Donor Affiliates (KODA) will display current information and statistics regarding organ/tissue donation and transplantation. KODA will provide brochures and other printed material regarding brain death declaration and donation criteria.

Kentucky Telco Federal Credit Union #100A

3740 Bardstown Road
Louisville, Ky 40218
(502) 459-3000

The KMA Credit Union. Offer your staff a fringe benefit that won't cost you a cent! Kentucky Telco is a Federal Credit Union with service centers located in Louisville, Lexington, Owensboro, and Frankfort, all delivering a full range of financial services. Offering members federally insured protection on their deposits, low cost loans, free checking, credit cards, Quest ATM services, 24-hour telephone service, and much more. Kentucky Telco is proud to be the only financial institution endorsed by the Kentucky Medical Association.

Key Pharmaceuticals #305

1011 Spearpoint Dr
Hendersonville, TN 37075
(615) 822-6326

Display cardiovascular, pulmonary/allergy, and dermatological products of interest to the medical community.

Kimberly Quality Care #406

100 Mallard Creek Road, Suite 300
Louisville, KY 40207
(502) 893-8888

Nation's largest home health care organization focusing on specialty areas such as IV infusion, rehabilitation, pediatrics, and traditional home care.

Knoll Pharmaceuticals #208

30 N Jefferson Road
Whippany, NJ 07981
(201) 887-8300

Lakeview Rehabilitation Hospital #209

134 Heartland Dr
Elizabethtown, KY 42701
(502) 769-3100

At Lakeview Rehabilitation Hospital we strive to assist people disabled by disease or injury including traumatic brain injury, spinal cord injury, stroke, amputation, major multiple traumas, chronic pain, multiple fractures, congenital deformity, burns, polyarthritis, pulmonary diseases, and other neurologic and orthopedic disorders including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy and Parkinson's disease to reach their maximum potential for an independent and productive life. Our 40-bed free-standing, fully licensed, comprehensive rehabilitation hospital in Elizabethtown offers patients and their families a calm, relaxed environment and an organized systematic approach to achieve the optimum recovery through inpatient and outpatient services in a cost effective manner.

Lederle Laboratories #214

One Cyanamid Plaza
Wayne, NJ 07470
(201) 831-4422

SUPRAX® cefixime is a third-generation oral cephalosporin antibiotic. It is useful in the treatment of otitis media, acute bronchitis, acute exacerbation of chronic bronchitis, urinary tract infections and pharyngitis. PROSTEP™ nicotine transdermal system, an adjunct to a comprehensive smoking cessation program, relieves the symptoms of nicotine withdrawal. VERELAN® (Verapamil HCl) — a calcium channel blocker for the treatment of hypertension.

Marion Merrell Dow, Inc #410

9300 Ward Pky
Kansas City, MO 64114
(816) 966-4000

Please stop by and let our representatives answer your questions regarding our products. Featured will be CARAFATE® (sucralfate) our unique, nonsys-

temic drug for the treatment of duodenal ulcers; CARDIZEM® CD (diltiazem hydrochloride) formulated as a once-a-day extended release capsule for the treatment of hypertension; SELDANE® (terfenadine) 60 mg tablets BID for seasonal allergic rhinitis and SELDANE-D® (terfenadine 60 mg and pseudoephedrine HCl 120 mg) extended-release tablets.

Marquette Electronics, Inc #132

6365 Timberview Dr
Howell, MI 48843
1-800-558-3408

Marquette Electronics diagnostics and supply representatives will be displaying the Marquette family physician products. These products include MAX 1 Stress System, MAC 6 ECG machine, CENTRA System (Stress, Holter, EGG Machine), MACPC ECG machine, 360 defibrillator and supplies (electrodes, mactrodes, and paper).

McNeil Consumer Products Company #229

801 Warrensville Road, Suite 55
Lisle, IL 60532
(708) 969-2772

McNeil Consumer Products Company invites you to visit our exhibit. Extra-Strength Tylenol® Gelcaps will be highlighted, together with Children's Tylenol® line of products. We will provide literature for the No. 1 Rx liquid ibuprofen product, Pediaprofen®. We will offer samples of Imodium A-D® (loperamide hydrochloride). Finally, we're proud to offer samples and literature of Mylanta® and Mylicon®. We encourage your attendance at our exhibit.

MD Systems #424

1170 E Broadway
Louisville, KY 40204
(502) 589-3207

MD Systems is the most unique office computer system available. It was developed and written by George C. Stege, III, MD, a Louisville physician who understands your specific needs. You need a system that is easy to use and understand and is geared to your spe-

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cialty. You should consider MD Systems. Consider the options. A system too complicated for your staff and not customized to your practice or MD Systems. Designed for the MD by an MD.

Mead Johnson Nutritionals #323

Evansville, IN 47721-0001

(812) 429-5000

We cordially invite you to visit our exhibit to meet our representatives who welcome the opportunity to discuss products and services of interest to you. Featured will be: Enfamil, Nutramigen, Poly-Vi-Flor, ProSoBee, Ricelyte, Tempa.

Mead Johnson Pharmaceuticals #317

Evansville, IN 47721-0001

(812) 429-5000

We cordially invite you to visit our exhibit to meet our representatives who welcome the opportunity to discuss products and services of interest to you. Featured will be: BuSpar (buspirone HCl); Desyrel (trazodone HCl); Monopril (fosinopril sodium).

Medic Computer Systems #403

8601 Six Forks Road

Raleigh, NC 27615

(919) 847-8102

The +MEDIC System is a comprehensive medical package that has been developed and refined over the last nine years and has over 3600+ users nationwide using our system. The +MEDIC System is designed with the flexibility that medical practices must have to operate effectively. By utilizing the system an operator can input charges for a patient's visit, produce the necessary insurance forms to hand to the patient at time of checkout, and schedule the patient for their follow-up appointment all from one charge entry program.

Medical Management

Resources, Inc

#101

10200 Linn Station Road, Suite 270

Louisville, KY 40223

(502) 423-5999

Provider of choice for electronic claim submission and related technological

services within the healthcare industry. Products are designed for needs ranging from point-of-sale devices for low volume submitters to fully configured office automation systems for the larger practice. We also offer consultation and educational services.

The Medical Protective Company

#211

PO Box 15021

Fort Wayne, IN 46885

(219) 486-0449

With over 90 years of experience in professional liability insurance, The Medical Protective Company continues to provide unsurpassed protection for physicians and dentists, exclusively.

Medical Technology Corporation #327

312 Whittington Pky

Louisville, KY 40222

(502) 339-1464

MTC plans to exhibit two products at the meeting. A patient management software program called PROMPT which electronically "writes" drug prescriptions and archives the information in a patient data base. This program facilitates the doctor's record keeping procedures in addition to warning physicians about patient drug allergies and contraindications of drug products. MTC will also exhibit a face/safety shield (SEPTA-SHIELD), which protects the face and neck area from human spray and splatter. This product is unique and patented because it rests comfortably on the chest instead of being held in place on the head.

Merck Human Health Division #226

4435 Waterfront Dr, Suite 204

Glen Allen, VA 23060

(804) 346-1084

Company formerly "Merck Sharp & Dohme."

Metropolitan Reference Laboratories, Inc

#411

11636 Lackland Road

St. Louis, MO 63146

(314) 991-1311

Metropolitan Reference Laboratories,

Inc (METRO) is a full service clinical laboratory dedicated to excellence of performance in all disciplines of laboratory medicine. Our primary goal is to provide exceptional service to clients in our region. Directed by Board Certified pathologists and PhD level scientists, the laboratory is equipped with state-of-the-art instrumentation and staffed by experienced supervisors, technologists, and cytotechnologists. At METRO our primary focus is on quality ... quality in testing ... quality in data handling ... and quality in reporting. METRO is a Corning Clinical Laboratory.

Norton Psychiatric Clinic

#224

200 E Chestnut St

Louisville, KY 40232

(502) 629-8850

For over four decades the Norton Psychiatric Clinic has been providing comprehensive psychiatric care in a medical setting. The 48-bed inpatient unit offers innovative treatment by a team of mental health professionals as well as the full medical resources of the Norton Hospital. The staff is experienced in managing a broad range of problems including patients who have both psychiatric and medical disorders.

Olsten HealthCare

#425

710 Executive Park

Louisville, KY 40207

(502) 895-4213

Olsten HealthCare, one of North America's largest providers of home health care, has offered home health care services for more than 20 years. Our network of 250 offices across the United States and Canada provides a range of experienced health care professionals from companions to registered nurses, physical/occupational/speech therapists and medical social workers. Confirming its commitment to quality, Olsten HealthCare is the first international home care and staffing services company to seek accreditation through JCAHO.

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Olympus Corporation #306

4 Nevada Dr
Lake Success, NY 11042
(516) 488-3880

OPTION Care #105

501 Darby Creek Road #5
Lexington, KY 40509
(606) 276-3152

Ortho Pharmaceutical #416

Route 202, PO Box 300
Raritan, NJ 08869-0602
(908) 218-6943

Visit the Ortho Pharmaceutical exhibit where representatives are prepared to discuss products and educational services of interest. Featured products include the country's most widely prescribed oral contraceptive, ORTHO-NOVUM® 7/7/7, an extensive line of gynecological therapeutics, including the most frequently prescribed vaginal antifungal TERAZOL®, and the broad-spectrum quinolone antibiotic, FLOXIN®.

Our Lady of Peace Hospital #413

2020 Newburg Road
Louisville, KY 40205
(502) 451-3330

Our Lady of Peace Hospital treats persons with emotional, behavioral, psychiatric, and addiction disorders. We offer short-term acute care programs for children, adolescents, and adults. Treatment options include inpatient, partial hospital, and intensive outpatient programs, as well as outpatient counseling available at Peace Counseling Centers. Come by our booth and see how, for 40 years, Peace has been helping to heal the whole person: body, mind, spirit and heart.

Parke-Davis #210

201 Tabor Road
Morris Plains, MH 07950
(201) 540-2000

Pfizer Laboratories #233

2400 W Central Road
Hoffman Estates, IL 60196
(708) 381-9500

Physicians Sales and Service #109

5215 Linbar Dr, Suite 203
Nashville, TN 37211
(615) 333-3852

PSS is a medical supply distributor. Some of the equipment we will demonstrate at the KMA Annual Meeting is as follows: Kodak DT6011 — Chemistry Analyzer; OBC Autoread — Hematology Analyzer; Puritan Bennet Renaissance Spirometer — Pulmonary Function Machine; ENT Acoustic Tympanometer. The equipment will be set up for doctor to be able to demonstrate. We will also have literature on PSS's services.

The PIE Mutual Insurance Company #422

9300 Shelbyville Road, Suite 1001
Louisville, KY 40222
(502) 339-7432
(KY WATS 1-800-228-7431)

The PIE Mutual Insurance Company of Cleveland, Ohio, now offers Kentucky physicians the advantages of an insurance program that has made it the leading professional liability carrier in Ohio. Owned and controlled by policyholders, the PIE is a non-profit company whose innovative program, unique in the industry, features claims handling by a specialty law firm, physician participation in all areas of operations including peer review of all applicants, and rate stability that rewards loss-free physicians with scheduled premium reductions.

Pratt Pharmaceuticals/ Pfizer, Inc #207

3609 Locust Circle E
Prospect, KY 40059
(502) 228-6345

Procter & Gamble Pharmaceuticals #326

17 Eaton Ave
Norwich, NY 13815
(607) 335-2937

Provided as a professional service in gratitude for your indicating "Dispense as Written" on prescriptions for Procter & Gamble products.

Professional Data Control, Inc #130

4010 Dupont Circle, Suite 700
Louisville, KY 40207
(502) 895-4204

Professional Data Control, Inc has been in business since 1976 and is based in Louisville. Our products are a full line of "Medical Practice Management Computer Systems" for reducing the outstanding accounts receivable of the medical practice, submitting insurance forms electronically, and many other functions involved with operating a practice efficiently.

Professionals' Purchasing Group, Inc #408

315 Guthrie Green, 3rd Floor
Louisville, KY 40202
(502) 581-9595

Professionals' Purchasing Group, Inc operates as a group purchasing organization for physicians and other business professionals. PPG offers an array of vendors, products and services at negotiated discount rates for their client base. Services include medical-surgical supplies, printing services, office supplies, financial and investment services, payroll services, automobiles, billing and collections, communication systems and many more. Call (502) 581-9595 or toll free 1-800-333-1PPG to find out more about Professionals' Purchasing Group.

RANAC Computer Corporation #225

3703 Taylorsville Road, Suite 217
Louisville, KY 40220
(502) 473-0518

CompreMED™ — Medical practice management system — Software modules can be customized to meet requirements of small practices or large clinics; includes electronic transmission of claims, patient information, A/R management, billing practice analysis, practice marketing, clinical and medical records, appointment scheduler and letter writer. Compreclaim™ — Electronically submit claims for Blue Shield, Medicare, Medicaid, Preferred Care, etc — no per claim charge. \$5,995 includes hardware, startup supplies and soft-

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ware. Software can be purchased separately.

Ransdell Surgical, Inc #115
752 Barret Ave
Louisville, KY 40204
(502) 584-6311

Reed & Carnrick Pharmaceuticals #203
257 Cornelison Ave
Jersey City, NJ 07302-9988
(201) 434-4000

Republic Bank & Trust Company #427
601 W Market St
Louisville, KY 40202-2700
(502) 561-7125
Since Republic Bank & Trust Company is the only bank endorsed by the Jefferson County Medical Society, you can be assured that our products and services are designed to accommodate your diverse financial needs. During KMA we will have information available on 100% Mortgage Financing, as well as the Preferred Client Services program and the Republic Advantage Account. Republic Bank & Trust Company's products and services make banking easy and convenient and offer you the advantage of local services.

Roche Biomedical Laboratories #332
6830 Wilcox Road
Dublin, OH 43017
1-800-282-7300
Roche Biomedical Laboratories, Inc is one of the largest clinical laboratory systems in the United States. Roche Biomedical offers a broad test portfolio, a strong base of technical dependability, a sophisticated computer and telecommunication technology and a comprehensive logistical system. All totaled, our company employs more than 8,000 individuals working out of facilities in more than 500 locations across the United States. Our laboratory network consists of 20 major regional laboratory testing centers located throughout the United States to facilitate accurate, precise and expedient test reporting any-

where within the continental United States.

Roerig Pharmaceuticals #433
235 E 42nd St
New York, NY 10017
(212) 573-2323

Ross Laboratories #200
625 Cleveland Ave
Columbus, OH 43216
(614) 624-6449
Ross representatives will feature the Ross Hospital Formula System, Similac, Isomil, Alimentum, and specialty infant formula. Additionally, your Ross representative will provide the most recent information on Suprax and Survanta. Ross Laboratories markets its infant formulas and pharmaceuticals only through the health care professional.

Saint Joseph Hospital #204
One Saint Joseph Dr
Lexington, KY 40504
(606) 278-3436

Salcris Systems #231
800 Concourse Pky
Birmingham, AL 35244
1-800-827-5444
Salcris Systems is the developer and marketer of the ProMed Medical Accounts Receivable System. For 12 years Salcris has provided top quality systems and support to thousands of physicians in the Southeast. With over 110 employees, Salcris is one of the largest providers of medical systems in the South. Salcris has offices in Birmingham, Atlanta, Tampa, Nashville, and New Orleans.

Sandoz Pharmaceuticals #222
59 Route 10
East Hanover, NJ 07936
(201) 503-8005
Sandoz Pharmaceuticals invites you to visit our exhibit booth where our representatives will provide you with the latest information on our products and any educational materials we may have available.

Sanofi-Winthrop Pharmaceuticals #103
228 Ridge Side Dr
Powell, OH 43065
(614) 436-1747

Savage Laboratories #415
60 Baylis Road
Melville, NY 11747
(516) 454-9071
Chromagen — The only liquid iron in a soft gelatin capsule
Mytrex — For the treatment of external candidal infections with inflammation
Trysul — Triple sulfa vaginal cream
Brexin LA — Cost effective antihistamine/decongestant
Doctar — Coal tar shampoo and conditioner
Alphatrex and Betatrex — Topical steroids

Searle #311
5200 Old Orchard Road
Skokie, IL 60077
(708) 470-6224

Shearson Lehman Brothers, Inc #324
200 S Fifth St, Suite 100N
Louisville, KY 40202
(502) 561-4012
Today's capital markets are crowded with investment choices, each with varying degrees of complexity and risk. Even for the most experienced investor, identifying the right investment opportunities at the right time can be a most difficult exercise. More and more investors are turning to professional portfolio management to enhance their investment returns and control risk. The consulting group of Shearson Lehman Brothers provides service in three basic areas: formulation of written investment objectives; manager search and selection; and performance monitoring and evaluation.

SKYCARE #102
217 E Chestnut St
Louisville, KY 40202
(502) 587-4788
In the early 1980s Jewish Hospital rec-



ognized the increasing need for a faster, more efficient mode of emergency transportation, a need that could no longer be answered by military helicopters. As a result, on July 1, 1982, Jewish Hospital announced the creation of SKYCARE, Kentucky's first emergency air ambulance. Since its first year of operation, SKYCARE has maintained strong ties to education, sponsoring hundreds of on-site seminars as well as regular trauma and Advanced Cardiac Life Support symposiums. SKYCARE's physicians and team members have also traveled through the region to answer questions at health fairs, medical conventions, and community events.

SmithKline Beecham Clinical Laboratories

#119

2277 Charleston Dr
Lexington, KY 40577
(606) 299-3866
Clinical laboratory.

SmithKline Beecham Pharmaceuticals

#407

12312 Olive Blvd, Suite 625
Saint Louis, MO 63141
(314) 576-4470

Representatives will be on hand to answer your specific questions and to provide information on our products and services.

Southeastern Data Systems, Inc

#106

1016 Weisgarber Road, Suite 110
Knoxville, TN 37909
(615) 584-1507

Featuring the easy-to-use VERSYSS MENDS II advanced practice management billing and accounts receivable software, plus fully integrated scheduling, electronic billing, medical records, and accounting modules which allow your system to expand with your needs. VERSYSS offers physicians a wide variety of hardware platforms including VERSYSS SOLUTION/I Multi-User System, VERSYSS SOLUTION/RISC system manufactured by IBM Corporation and a low-end PC based system.

SpectraCare, Inc

#205

111 E Kentucky St
Louisville, KY 40202
(502) 584-4040

SpectraCare, Inc is a comprehensive home health care organization. Our goal is to provide superior care to patients by utilizing the best in people, programs, methods, and technology. Our distinct focus on hi-tech products and services allows us to provide, under physicians orders, everything from case management and specialized nursing to IV infusion pharmacy. We bring a world of health care home.

Squibb US Pharmaceutical Group

#104

PO Box 4500
Princeton, NJ 08543
(609) 252-4000

Squibb US Pharmaceutical Group has long been a leader in the development of therapeutic and diagnostic products for the prevention, detection, and treatment of diseases. You are cordially invited to meet our representatives who will be available at our exhibit to discuss our full line of health care products, including Pravachol (Pravastatin Sodium), Capoten (Captopril), and Duricef (Cefadroxil Monohydrate, USP).

Summit Pharmaceuticals

#419

5683 Woodbridge Lane
West Chester, OH 45069
(513) 860-1199

3M Pharmaceuticals

#404

3M Center
Saint Paul, MN 55144-1000
(612) 733-1110

Unico, Inc

#122

125 N Weinbach Ave, Suite 230
Evansville, IN 47716-6506
(812) 479-3932

Unico, Inc is a regional dealer of The Medical Manager Office Management System. Unico, Inc can provide a complete system, including software, hardware, and all training. Our exhibit will contain a complete demonstration of

The Medical Manager package. Information will be available on the Kentucky EMC (Electronic Media Claims) package.

United States Air Force

#134

2515 Perimeter Place Dr
Nashville, TN 37214-3671
(615) 889-0723

United States Army Medical Department

#414

5111 Leesburg Pike, Suite 638
Falls Church, VA 22041-3258
(703) 756-8118

Physician Placement Service for the US Army Medical Department, both active duty and reserve. Information will be available about financial assistance as well as the large number of challenging positions in both the Active Army and US Army Reserve.

University of Kentucky Hospital

#417

Chandler Medical Center
800 Rose St
Lexington, KY 40536-0084
(606) 233-5000

The physicians practicing at UK Hospital and Kentucky Clinic are committed to meeting the consultation and referral needs of physicians throughout the Commonwealth. Comprehensive services include cancer and cardiac specialties, neurosciences, obstetrics and gynecology, and pediatrics. The 473-bed hospital offers Level I trauma care, organ transplantation, neonatal intensive care, magnetic resonance imaging, and multidisciplinary programs. Visit our booth to learn more about our physician access services, including the UK-MDs physician-to-physician 800 number.

The Upjohn Company

#432

600 Vine St, Suite 2704
Cincinnati, OH 45202
(513) 723-1010

VersaCom, Inc

#328

5652 W 74th St
Indianapolis, IN 46278
1-800-486-7714

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Whitby Pharmaceuticals, Inc #418

PO Box 84054

Richmond, VA 23261-5054

(804) 254-4347

Lortab Line — a complete line of narcotic analgesics in both liquid and tablet form for moderate to moderately severe pain.

Wismer*Martin #202

N 12828 Newport Highway

Mead, WA 99021

(502) 466-0396

Wismer*Martin has been providing computer systems and services for the management of health care practices since 1980 and has 1500 installations in 47 states. SM*RT Practice is our full-featured billing system with switch-settable specialty options that provide flexible billing and collection capabilities plus automatic statement and insurance claim generation. Added features include clinical patient information, referral tracking, recall management, managed care tracking, electronic claims and remittance, electronic scheduling, installation, training, software and hardware support, and updates.

Wyeth-Ayerst/

A.H. Robins

401 & 401A

PO Box 8299

Philadelphia, PA 19101

(215) 971-4772

Wyeth-Ayerst welcomes the opportunity to continue their longstanding association with the Kentucky Medical Association through participation in your exhibit program. Our professional representatives will welcome the opportunity to visit with you and discuss any inquiries you may have concerning our products including ISMO, Premarin, Lodine, Verelan, Tenex . . .

Wyeth Laboratories

#426

787 Longwood Road

Lexington, KY 40503

(606) 223-1964

CONTRIBUTOR RECOGNITION

We would like to thank the following organization for their special contribution to this year's Annual Meeting:

Syntex Laboratories
3401 Hillview Ave
Palo Alto, CA 94303

AN INVITATION

For a chance to visit with your Annual Meeting Exhibitors, join us each morning (Tuesday, Wednesday, & Thursday) in the Lounge area, located in the center of the Lexington Center, from 8:00 am - 9:00 am, for free coffee & danish.

Ardis Dee Hoven, MD Nominated for KMA President-Elect

Ardis Dee Hoven, MD, has been nominated by the Fayette County Medical Society for the office of President-Elect of the Kentucky Medical Association.

Dr Hoven has been dedicated and effective in her contributions to KMA through extensive service. Membership on numerous committees and the chairmanship of several have established Dr Hoven as a very knowledgeable member of the Board of Trustees — the first woman to ever be elected to the KMA Board. She has chaired the Ad Hoc Committee on the Development of AIDS Guidelines, Committee on Medicare and Other Governmental Medical Programs, and from 1987 to present has chaired the Committee on Community and Rural Health. Dr Hoven also currently serves on the Professional Liability Insurance Committee, as an AMA Alternate Delegate, and as KMA Vice-President.

Other professional affiliations include the American Society of Microbiology; Executive Committee of the Fayette County Medical Society; and Chairman of the Fayette County Board of Health.

A native of Cincinnati, Ohio, Dr Hoven received a bachelor of science degree from the University of Kentucky in 1966, followed by a medical degree from the University of Kentucky College of Medicine in 1970. All of her post-graduate training was accomplished at the University of North Carolina-Chapel Hill. She served an internship there in 1970-71, completed a residency in internal medicine in 1973, and accomplished a fellowship in infectious disease in 1973-75.



Dr Hoven is affiliated with the Lexington Clinic, Department of Medicine, Division of Infectious Diseases. She is on the active staff and is hospital epidemiologist at St. Joseph Hospital, Lexington; is on the consulting staff of Humana, Central Baptist, and Good Samaritan Hospitals in Lexington; and is a member of the Active Voluntary Faculty at the University of Kentucky Medical Center. *KMA*

"SHAHAJJO!"

CARE



"Shahajjo!" in Bangladesh. "Erdu!" in Ethiopia. "Ayudame!" in Central America. In any language, when the world cries "Help!" CARE is there. Please. Be there for CARE.

1-800-242-GIVE

When you don't know all the medicines your patients are taking, protecting their health is a crap shoot.



Many patients may be risking their health by combining prescriptions and/or OTCs that shouldn't be mixed. Uninformed medicine use is risky. Especially for older patients.

Counseling patients about all their medicines improves their odds of getting well and staying well.

Write to NCPIE for a free medicine counseling kit.



EVERYONE WINS WHEN YOU TALK

Please send me a free Medicine Counseling Kit.

Name _____

Organization _____

Street _____

City _____

State _____

Zip _____

Mail to:

National Council on Patient Information and Education

666 Eleventh Street, NW, Suite 810
Washington, DC 20001

To fax your request -- (202) 638-0773

RATES AND DATA

All orders for classified advertising must be placed in writing and will be subject to approval by the Editorial Board. The right is reserved to decline or withdraw advertisements at the publisher's discretion.

Deadline: First day of month prior to month of publication.

Word count: Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

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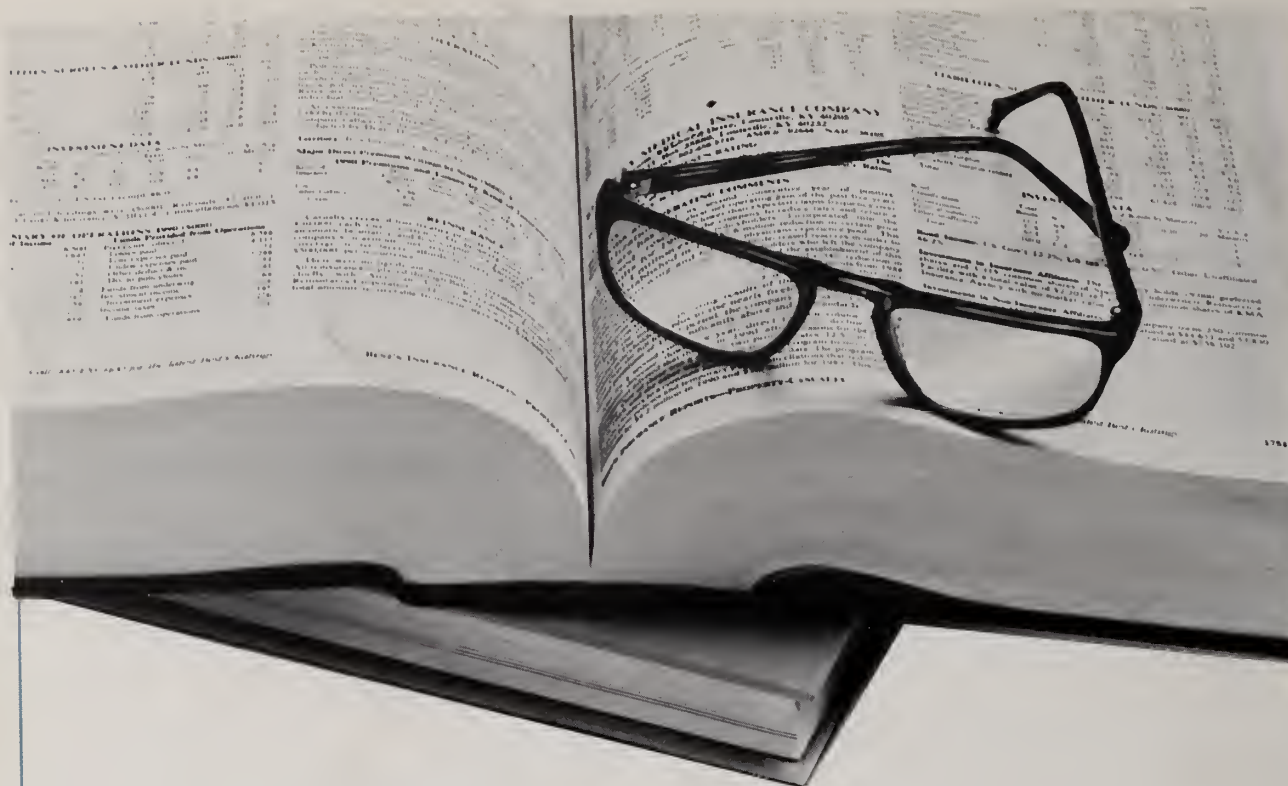


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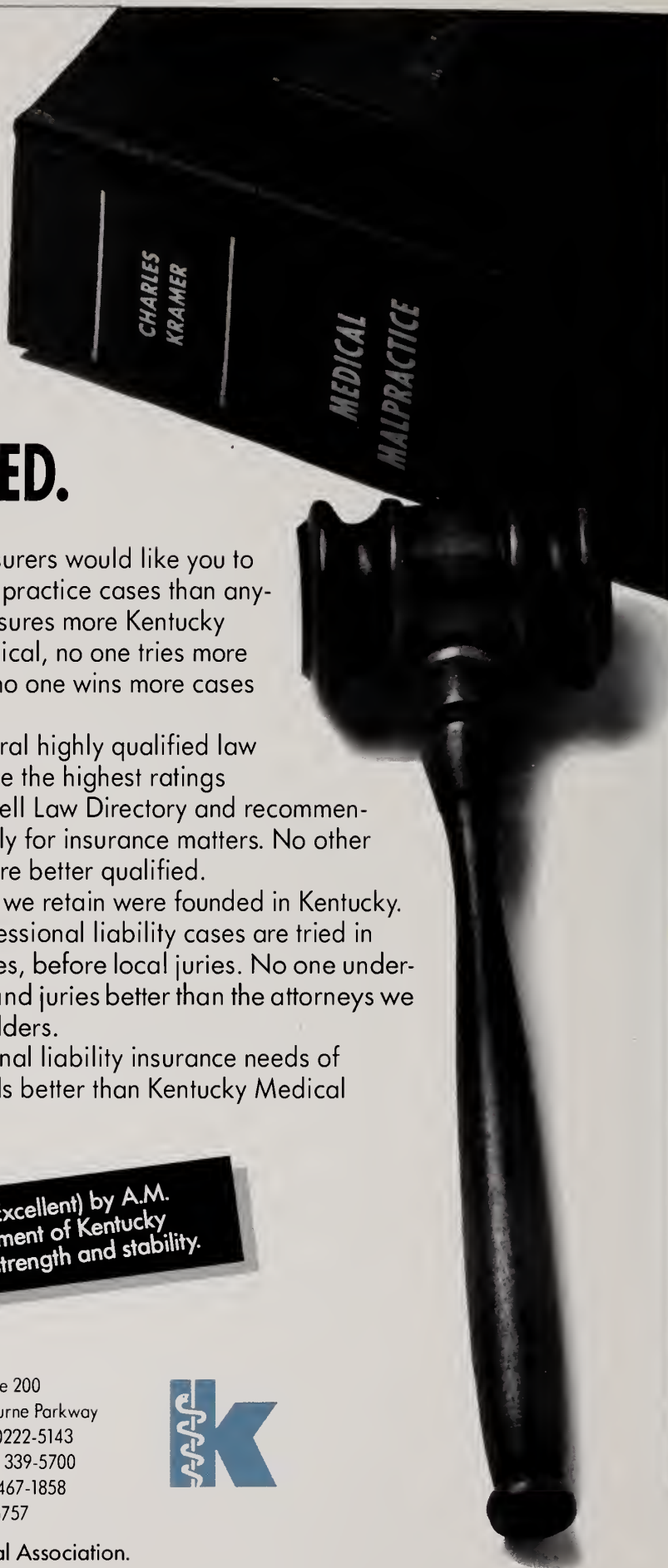
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VOLUME 90, NUMBER 9

SEPTEMBER 1992

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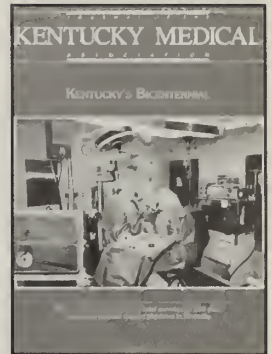
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COVER: View of a present day operating room equipped for ophthalmologic surgery. The surgeon is using the operating microscope whose base and mount is to the left of the photograph. His assistant or nurse can view the operative field simultaneously through the other set of binocular eye-pieces. The plastic cover is sterile and covers the most accessible portion of the scope and its controls. In the immediate foreground is the Mayo stand containing the surgeon's other instruments. The apparatus in the background of right is designed for continuous aspiration and irrigation of the posterior chamber in treating disease of the vitreous. The anesthesiologist and anesthesia apparatus are obscured in this view but is equally expressive of present day "high-tech" medical and surgical treatment methods.

INSET: Liebreich's aphthemascope, ca 1855 from the Historical Collections at UL Karnhauser H.S. Library, Louisville, KY. The first ophthalmoscope was devised by Hermann von Helmholtz, 1850. It was improved upon by Richard Liebreich, MD, of Kanigsberg, incorporating Reute's concave perforated mirror. The smallest lenses were far correcting refractive variations in the examiner's eye. They were held in place by a lens clip (only half of which is present in this instrument) which was the concept of Coccius. There were in this case several larger biconcave lenses for indirect examination.

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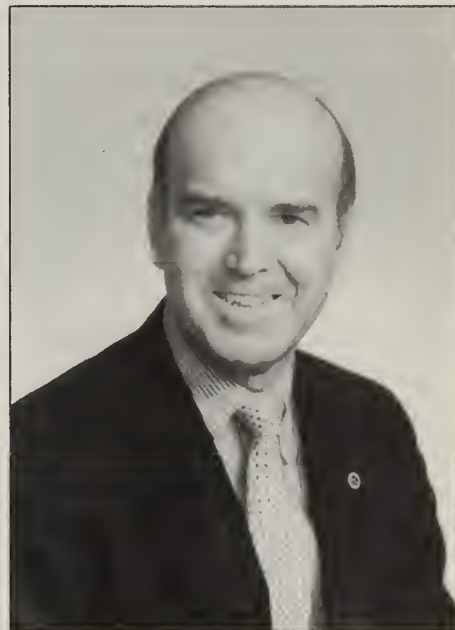
We have always been told that time passes quickly as we grow older. By the time you read this I will have almost completed my year as President. The year has gone by quickly — it seems such a short time since I was honored by, and was proud to accept, this prestigious position. I want to thank all of the membership for this opportunity to serve.

In my inaugural address I spoke of professionalism — the doctor-patient relationship. I had hoped to promote this more during the year but have been sidetracked by other pressing issues. At that time, I quoted Dr John Ring who said, "Medicine is about taking care of sick people. It's about helping all Americans lead healthier and more productive lives. It's about being good, ethical professionals. And we must preserve, protect, and promote medicine's professionalism. By professionalism I mean that dedication to competence, compassion, and moral accountability that has characterized all the best doctors in every era since Hippocrates." I feel this is worth repeating since I don't know how it can be stated better. It is essential that we dedicate ourselves to renewing our efforts to regain and reestablish that special relationship with our patients which has been compromised by all of the other external pressures such as malpractice litigation, the hassle of voluminous paperwork, new governmental regulations, and many other factors that distract us from our primary

mission. We must not be distracted from our most precious commodity — the doctor-patient relationship.

What can we do to help reestablish this relationship? We can schedule our appointments so that patients are not kept waiting unnecessarily in the office or the hospital emergency room. Remember — our patients' time is valuable also. Try to accept calls as they come in rather than to call back at the end of the day. It is difficult to do this at times but is rewarding in the end. Call your patients to inquire about their progress — not all, obviously, but those who are acutely ill or having a difficult time. Also, call your patients about test results they may be concerned about — positive or negative. They will appreciate this. Many other things can be done to aid our patients. These are problems you can solve because you are a human being and have special skills. Society's problems can be solved by reaching out to those who were not born with your special talents and skills. We must be competent, caring physicians, recognizing the personal as well as the medical needs of our patients.

This past year has been one focused primarily on health care reform. The Governor's Task Force and Commission will propose new programs for health care reform. Your KMA leadership and staff have worked very hard developing our own proposals for health care reform to insure medicine's input into solving this problem. The Governor's program



S. Randolph Scheen, MD

"It is essential that we dedicate ourselves to renewing our efforts to regain and reestablish that special relationship with our patients which has been compromised by all of the other external pressures . . ."

“ . . . We need not just your dues but your involvement in KMA to work together and be vocal for what you believe.”

will affect every physician in Kentucky with respect to the delivery of health care — it is a critical issue. Your KMA organization has faced critical issues before. In the 1970s, when many physicians in Kentucky could not obtain malpractice insurance, we faced a crisis. KMA, however, faced that challenge. Beginning with just a concept, they developed our Kentucky Medical Insurance Company to provide malpractice insurance for the physicians of Kentucky. This company has grown over the years to become one of the premier companies writing malpractice insurance in the country — which recently received an A-Excellent rating from A. M. Best Company. This is a rating only given to “companies having a strong ability to meet their policyholder and other contractual obligations over a long period of time.” I am proud of KMA’s accomplishments in that crisis and pledge our strongest effort to represent the best interests of Kentucky physicians in health care reform.

Your KMA organization represents you at every level of

society and does it with many members who are non-participants. In order to represent you even better, we need not just your dues but your involvement in KMA to work together and be vocal for what you believe. We need to work together — not to protect income but to insure the continuation of the best medical care system in the world.

You are needed to help develop programs to be sure no one is left out because they have no money. You are needed to give your endeavors to the poor as well as all who are in need of your help.

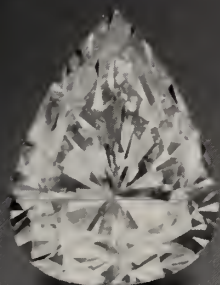
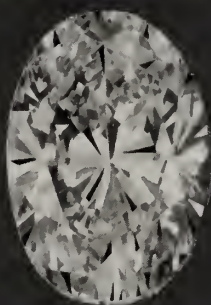
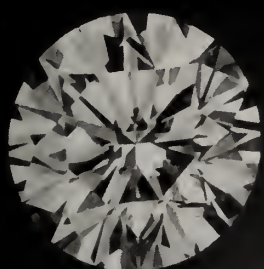
We must solve these problems, for if we don’t, others may solve them for us and we may not be happy with their solutions. Most of all, we do it because it’s the right thing to do.

Let us now recommit ourselves to those values that we so highly respected when we chose to enter this difficult, demanding, and most rewarding profession in the first place.

“Let us care, let us do no harm, let us make a difference.”

S. Randolph Scheen, MD
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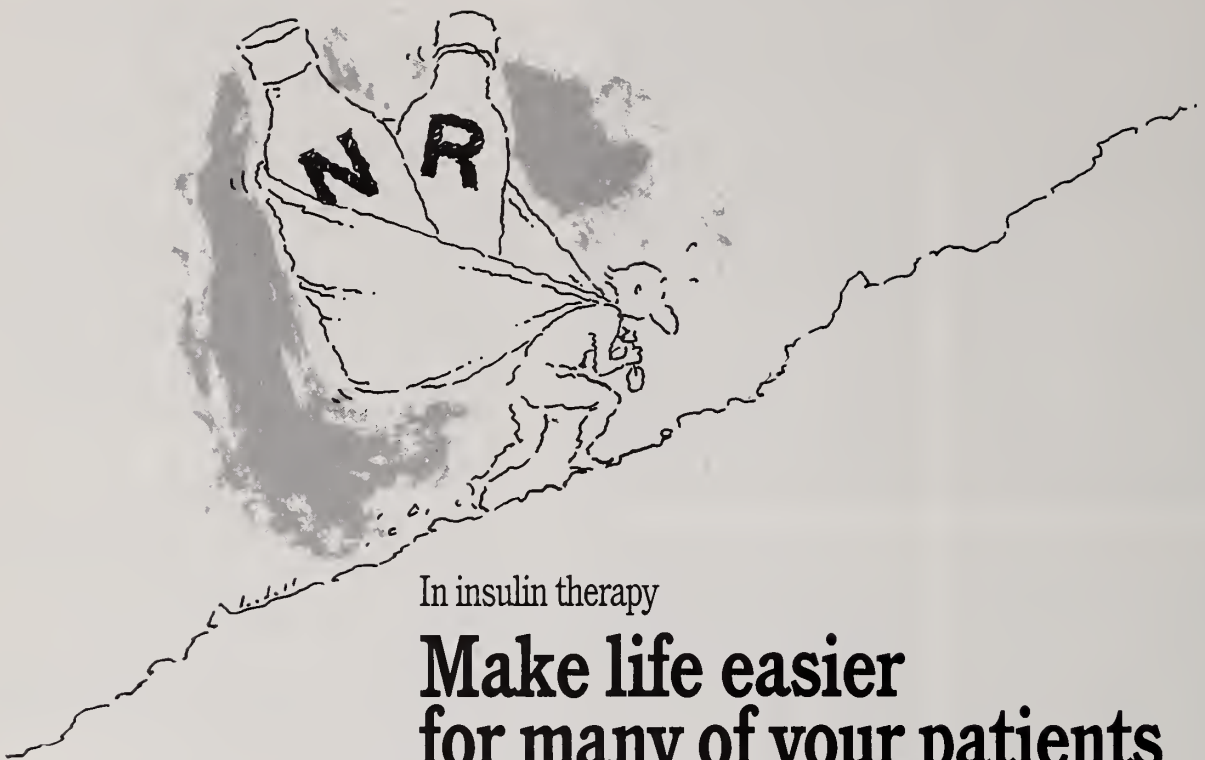
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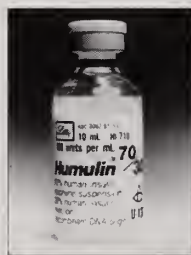
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Bronchoscopy for Pulmonary Hygiene in the Intensive Care Unit

David S. Overstreet, MD; Thomas M. Roy, MD; Cheryl L. Fields, MD

The safety and ease of fiberoptic bronchoscopy recommends its use in the intensive care unit. In critically ill patients, the procedure may be a valuable diagnostic or therapeutic tool. In most instances, the diagnostic indications are well defined. The therapeutic indications for bronchoscopy, however, are more controversial. They center around using the bronchoscope for removal of secretions, mucus plugs and reversing atelectasis in mechanically ventilated patients. This report examines the small but definite risk of therapeutic bronchoscopy in mechanically ventilated patients.

This application of bronchoscopy in patients requiring intensive care has generated a number of observations concerning the effects of the procedure on the patient's tenuous cardiopulmonary reserve. We report two patients who demonstrated adverse effects from bronchoscopy for pulmonary hygiene. A review of the potential problems with this procedure in mechanically ventilated patients should help the clinician select the appropriate modality for removal of secretions and treatment of atelectasis in the critically ill patient.

From the Division of Respiratory and Environmental Medicine, University of Louisville School of Medicine, and the Louisville Veterans Administration Medical Center, Louisville, KY.

Introduction

The flexible fiberoptic bronchoscope was introduced to clinical medicine in 1968. Twenty years of use has confirmed its safety as a diagnostic tool for many pulmonary disorders. As clinicians rapidly acquired the necessary skill to examine the lower respiratory tract, the procedure was proposed as a means of maintaining pulmonary hygiene in mechanically ventilated patients who have limited ability to clear their secretions.

While there is no doubt that the bronchoscope can be effective in removing excessive secretions, there is a lack of consensus as to whether this is a better method of care than standard chest physiotherapy. An example of the divergence of opinion can be appreciated by the practice patterns of different surgical intensive care units. The University of Louisville has reported performing 41 bronchoscopic examinations in their surgical intensive care unit over an 18 month period for suspected lobar collapse and atelectasis.¹ In contrast, the surgical intensive care unit at the University of Maryland reports less than 10 such bronchoscopies a year and cites the Maryland Institute for Emergency Medicine as using bronchoscopy for retained secretions in only 59 of 7204 patients treated over a 7 year period.²

Case Reports

Patient 1 — D.H., a 33-year-old female with essential hypertension, was brought to the hospital by EMS after she lost consciousness while watching television. On arrival to the Emergency Department she was stuporous and combative, but could move her extremities. A CT scan of the head showed a diffuse subarachnoid hemorrhage. She was intubated and supported on mechanical ventilation. Repair of a ruptured aneurysm was to be performed when she had stabilized. Her chest radiograph on admission showed increased interstitial markings.

On the second hospital day, bedside bronchoscopy was attempted to remove excessive secretions and obtain a diagnostic bronchoalveolar lavage (BAL). The patient experienced a significant decrease in her oxygen tension as measured by pulse oximetry and the procedure was aborted. There was no change in the AP chest radiograph.

On the third hospital day, the procedure was repeated. During the bronchoscopy the patient developed hypoxemia that was less pronounced than that which had occurred the day before. BAL was not attempted. No change was observed on the AP chest radiograph after bronchoscopy.

On the fourth hospital day, the patient under-

Bronchoscopy for Pulmonary Hygiene in ICU

Table 1. Indications and results of bedside bronchoscopy in the patients described.

First Patient	Indication	Complication/ Benefit
1st procedure	Secretion removal BAL	Severe fall in PoO_2 Procedure aborted
2nd procedure	Same	Fall in PoO_2 BAL not obtained
3rd procedure	Same	BAL Performed-WNL CXR unimproved
4th procedure	Secretion removal Respiratory failure Pneumonia	No improvement in CXR or o/A ratio
5th procedure	Secretion removal	No improvement in CXR or o/A ratio
6th procedure	Secretion removal	No change in CXR or oxygenation
Second Patient		
1st procedure	Atelectasis	Severe hypertension
2nd procedure	Atelectasis	Severe hypertension on porenterol antihypertensives

went tracheostomy. A third bronchoscopy was performed through the new airway on the sixth hospital day. The BAL was obtained and the results were unremarkable. On the eighth hospital day, the patient was diagnosed with nosocomial pneumonia after developing fever, leukocytosis, and a new density on her chest radiograph. Parenteral antibiotics were started. Three additional bronchoscopies were done at the bedside with minimal effect on the chest radiograph (Table 1). The patient was eventually weaned from the ventilator and reevaluated for elective neurosurgery.

Patient 2 — C.F. is a 30-year-old male with a long history of essential hypertension and lack of compliance with his medical treatment. He was admitted to neurosurgery with blood pressures in the range of 260/130 mm Hg after experiencing a generalized tonic-clonic seizure. The CT of the head confirmed an intracerebral hemorrhage involving the right basal ganglia. The patient required intubation and mechanical ventilation.

Bedside bronchoscopy was attempted on the second hospital day for treatment of plate-like atelectasis in the right lung. During the procedure, the patient's systolic blood pressure returned to 240 mm Hg and the procedure was aborted. Nitro-

prusside and nitroglycerin drips were required to reduce his blood pressure. Later the same day, the procedure was attempted again while on the vasodilator drips. The patient responded in a similar fashion by raising his systolic blood pressure to 230 mm Hg. The procedure was terminated before the airways could be thoroughly examined. The chest radiograph was unchanged. A tracheostomy was performed on the third hospital day and pulmonary toilet was subsequently maintained by standard chest physiotherapy.

These two patients were purposely chosen to illustrate the potential adverse effects of bedside bronchoscopy. Presumably many other patients in this unit had bronchoscopy performed without such dramatic cardiopulmonary responses. The two patients that we profile were treated in the same intensive care unit during the same time period by different intensivists. Because the patients were treated at the end of an academic year by seasoned physicians, we feel that their care accurately reflects their physicians' favorable bias for bronchoscopy as a means of pulmonary toilet.

Discussion

Some physicians believe that bronchoscopy should play a major role in managing the retained secretions, mucus plugs, and atelectasis that occur in all critically ill patients requiring mechanical ventilatory support.³ They correctly observe that the procedure can be quickly performed by experienced endoscopists through an artificial airway.

Proponents of this method of pulmonary hygiene also claim that the procedure is efficacious and some studies support this observation.^{1,4} Unfortunately, there are no studies to suggest that bronchoscopy is more effective than properly performed chest physiotherapy.⁵

The ease and safety of bedside bronchoscopy through an artificial airway is often quoted. The current medical literature suggests that the procedure can be safely performed if all variables are properly controlled and the patients are carefully selected. The same literature, however, indicates that critically ill patients are a subset that should be approached with caution and treated as high risk candidates because of their limited cardiopulmonary reserve.⁶

The complications of bronchoscopy can occur from the anesthesia and sedation needed for the procedure, from the procedure itself, and

from ancillary procedures such as transbronchial or mucosal biopsy. In this report we will address only those problems that might occur from the procedure itself in a mechanically ventilated patient.

Passage of the bronchoscope through the endotracheal tube in patients on mechanical ventilation narrows the lumen of the artificial airway. This results in predictable alterations in airflow and pulmonary mechanics. A high exhalation resistance quickly develops and a PEEP effect occurs in most patients almost immediately. Using a standard 5.9 mm bronchoscope through an 8-mm cuffed endotracheal tube results in approximately an elevenfold increase in airway resistance.⁷ When the bronchoscope is used through endotracheal tubes with an internal diameter of 8 mm or more, the mean tracheal PEEP is 10.4 ± 9.3 cm H₂O. While such an increase in PEEP should be helpful in recruiting alveoli and offsetting hypoxemia, the frequent and sustained suctioning that occurs during the procedure reduces lung volume and generally allows alveoli to collapse. The PEEP also contributes to an increased peak ventilator pressure (PIP) with the mean of 52.8 ± 13.9 cm H₂O. These peak pressures are sufficient to cause mediastinal emphysema or pneumothorax in normal lungs if precautions are not taken to maintain reasonable pressure limits. For this reason, most investigators advise that any preset machine PEEP be discontinued during FFB through the endotracheal tube.⁸

The presence of the bronchoscope in the lung decreases the patient's FVC and FEV₁. Each of these values returns to normal after the bronchoscope is removed. In contrast, the FEF 25–75% remains significantly below the precalculated level after the removal of the instrument. The FEF 25–75% is considered a measure of the patency of the medium and small airways. Closure of these airways may contribute to ventilation/perfusion mismatch and the persistent hypoxemia often observed for hours after the procedure.⁷

In patients who have had hemodynamic monitoring during bronchoscopy, a definite cardiovascular response can be observed. Cardiac output increases with passage of the bronchoscope and is especially augmented during suctioning. It returns to normal baseline values approximately 15 minutes after the procedure is discontinued.⁸ Mechanical irritation of the airways results in a reflex sympathetic discharge. This catecholamine release also increases mean arterial pressure, heart rate, mean pulmonary ar-

tery occlusion pressure, and the heart's rate-pressure-product. These changes are also most pronounced during suctioning.^{9,10}

The most common complication observed during and after bronchoscopy is a fall in PaO₂. To some extent the degree of expected desaturation is related to the patient's underlying pulmonary dysfunction.¹¹ The PaO₂ has been observed to deteriorate by as much as 20 mm Hg.¹² The impairment in oxygenation may persist for up to 2 to 4 hours. If there has been a significant instillation of normal saline or if bronchoalveolar lavage (BAL) has been performed, approximately 23% of ventilated patients will have a post-bronchoscopy increase in their supplemental oxygen requirements.^{11,13} Even a minimal alteration in oxygen exchange may significantly affect critically ill patients with limited cardiopulmonary reserve.

To some extent this fall in arterial oxygen tension can be offset by performing the procedure with a FIO₂ of 100%. The positive end expiratory pressure (PEEP) that results from the limitation of expiration caused by presence of the bronchoscope in the airway may also prevent the arterial oxygen tension from falling precipitously in a small group of patients. Likewise, some improvement might be expected in oxygenation with removal of secretions and mucus plugs. Unfortunately, as illustrated by one of our patients, neither of these mechanisms reliably insures good oxygenation.

The predictable decline in oxygenation has many potential explanations. Suctioning, instillation of lidocaine or saline, and a decrease in tidal volume predispose to hypoxemia. Excessive suctioning diminishes the auto-PEEP effect, decreases the lung volume below the FRC, and removes oxygen enriched gas from the lungs. A ventilation-perfusion mismatch may result from bronchospasm precipitated by stimulation of irritant receptors in the lower airways.¹²

Because the bronchoscope has access to only the fourth and fifth branchings of the airways, some investigators have suggested the instillation of larger amounts of normal saline to lavage mucus plugs from more distal airways. This maneuver was performed 43 times in six patients and resulted in an unpredictable fall in the PaO₂/PAO₂ and chest compliance. The rate of recovery was also unpredictable and in some cases took as long as 8 hours.¹⁴ True shunting may occur if significant surfactant is diluted by BAL fluid and alveolar collapse occurs.¹²

In most studies of mechanically ventilated

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patients, the PaCO_2 rises and pH falls during bronchoscopy. These abnormalities reflect the difficulty maintaining alveolar ventilation when the bronchoscope partially occludes the lumen of the artificial airway and the effective tidal volume is decreased by suctioning. The return of PaCO_2 to baseline lags behind the correction of oxygenation when the bronchoscope is removed.

There is always a potential for hypoxemia-induced arrhythmias, myocardial ischemia induced hypotension, and endogenous catecholamine-induced hypertension.⁹ Minor arrhythmias occur in 70% of patients, while significant atrial and ventricular arrhythmias are reported in 11% of patients.^{1,15} The primary risk factor is hypoxemia during and after the procedure. Other risk factors in the critically ill patient would include advanced age in men, the presence of coronary artery disease, and chronic obstructive pulmonary disease. The need for maintenance doses of digitalis, quinidine, and theophylline may also indicate increased risk.¹¹ Cardiopulmonary arrest has been rarely reported with an incidence of only 0.02%.¹⁶ If bronchoscopy is proposed, extreme caution should be exercised in patients with hypotension, bradycardia, or supraventricular rhythms.¹¹

Another potential hazard of bedside bronchoscopy in the intensive care unit is introducing potential pathogens into the lower respiratory tract. While the normal oropharynx is colonized by a complex microbiological flora in high concentrations,¹⁷ the seriously ill hospitalized patient frequently has the upper airways or endotracheal tube recolonized with potential pathogens.^{18,19} Several studies using methylene blue as a marker indicate that the bronchoscope is contaminated during its passage through the oropharynx or endotracheal tube.^{20,21} The potential for introducing microbial pathogens is unavoidable.

The incidence of fever after bronchoscopy is approximately 16% and is most often attributed to microatelectasis in the situation of relative surfactant deficiency. Pulmonary infiltrates occur in 0.6%.²² Either of these occurrences may be related to the introduction of pathogenic microorganisms into the lung during passage of the bronchoscope.

Nosocomial infection is always a risk if the bronchoscope is not adequately cleaned and disinfected prior to use.¹⁴ Bacteremia has been documented during bronchoscopy, but no deleterious effects have been shown in the ambulatory population.²³ No controlled studies of endoscopy-in-

duced bacteremia in the critically ill population have been published.

It is a paradox that bronchoscopy for pulmonary hygiene is often necessary in neurology patients who are obtunded or have difficulty with coughing. Like any mechanical manipulation of the airway, bronchoscopy may increase intracranial pressure (ICP) by reflex mechanisms. ICP may also be elevated as the transient PEEP that occurs during bronchoscopy retards venous drainage from the head.

Two situations emerge in which bronchoscopy assumes a therapeutic role and the benefits justify the risks for the mechanically ventilated patient. The first situation correlates the patient's radiographic appearance with the expected success of bronchoscopy. If lobar atelectasis has occurred from retained secretions and has an air bronchogram pattern that is visible only to the level of the segmental bronchi, the bronchoscopy will likely be effective. On the other hand, if there is a distal air bronchogram that extends to subsegmental bronchi or beyond, effective bronchial suctioning is generally precluded and chest physiotherapy is considered more appropriate.²⁴ The second situation in which bronchoscopy for pulmonary hygiene is acceptable is after standard chest physiotherapy has been properly administered for excessive or retained secretions without positive results.

In summary, flexible fiberoptic bronchoscopy should not be performed in the critically ill unless there are valid indications and the therapeutic advantage to be gained outweighs the potential risks. Although the risk is generally low, patients on mechanical ventilation should be approached with great caution. The literature supports bronchoscopy for removal of secretions and treatment of atelectasis when conventional chest physiotherapy is not successful.

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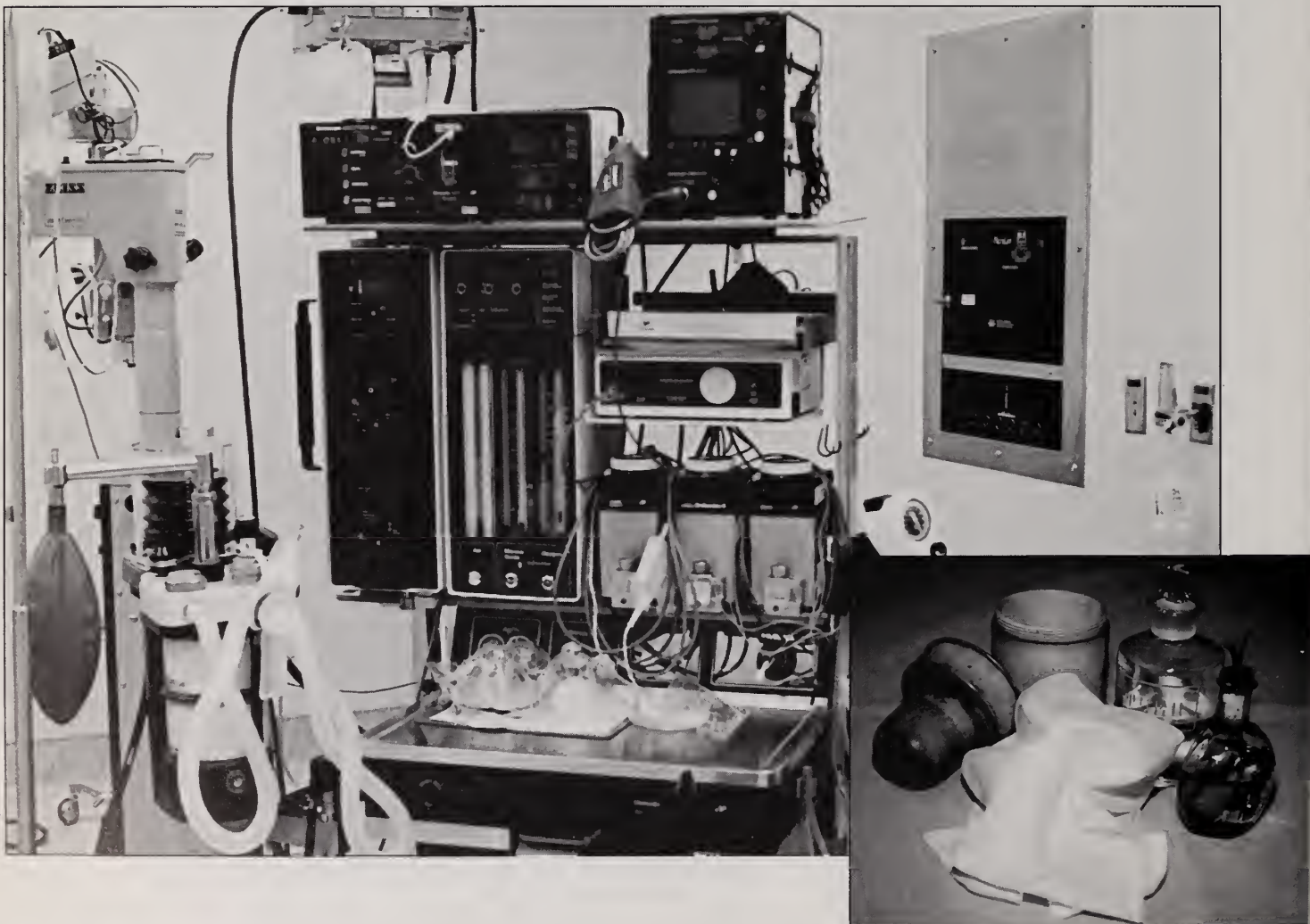
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Kentucky's Bicentennial and a Brief Overview of 200 Years of Medical Practice and the Physician

Eugene H. Conner, MD

The second part of a two-part section



The first half of the 19th century was a period of national expansion closely associated with an increasing population growth principally as a result of the immigration of western European natives. In the latter part of this period, progress was made in the development of social, cultural, and humanitarian aspects of society. Benevolent societies had been established in larger towns and cities, which assisted charities traditionally operated by churches and religious orders.

The concept of providing a hospital for the insane emerged in Lexington, KY, in 1816, under the leadership of Andrew McCalla, who with 55 subscribers, incorporated the "Fayette Hospital." The hospital was completed with additional funds from the State Legislature in 1824, and was ready for the reception of patients from throughout the state. The cost of its operation soon outgrew the resources of charitable citizens and, in 1826, the State of Kentucky reimbursed the contributors and continued its function as the Eastern Lunatic Asylum. It was the first such institution in the West and the second in the United States.^{1,2}

The moral or non-restraint treatment and management of the insane crossed the Appalachian Mountains early in the 19th century largely as the result of the influence of the work of the Quaker philanthropist and reformer, William Tuke [1732-1822] of York, England (1796)³; Philippe Pinel, MD [1745-1826] of Paris, France (1798)⁴; and Dorothea L. Dix [1802-1887] of Boston, MA (1841-45).⁵ Moral treatment of the insane was begun in this institution by John R. Allen, MD, the newly appointed superintendent (1844).⁶ Institutional care for the insane in Kentucky continues to be supported by the state, although during the intervening century and a half many

changes in focus and methods have been adopted.

Before mid-century, the medical profession had contributed to the cultural aspects of education by its intellectual and financial support of the Medical Department of Transylvania University. The first complete medical faculty was assembled in 1823.⁷ In Louisville, several medical schools appeared and thrived during part of the same period: Louisville Medical Institute (1837),⁸ which became the University of Louisville Medical Department (6 May 1846), and The Kentucky School of Medicine (1850).⁹

Daniel Drake, MD [1785-1852], led a campaign for state support for educating the blind in Kentucky, as he had successfully done in Ohio. With the assistance of many others, The Kentucky School for the Blind was established in Louisville, May 1842.¹⁰ In 1823, another state supported school, The Kentucky School for the Deaf, was opened in Danville, KY, "under the protectors of Centre College."¹¹

Although there had been numerous hospitals constructed in Europe during the latter half of the 18th century, such activity was delayed in the British colonies of North America and the new United States, with the notable exception of the Pennsylvania Hospital of Philadelphia which first received patients in 1756.¹² As early as 1817, a charter was obtained for a Public Hospital to be constructed in Louisville to serve the public and the transient ill or injured mariner on the Ohio River.¹³ This hospital, the first "general" hospital in Kentucky, received patients beginning in 1823 and was known as the Marine Hospital — later, Louisville City Hospital. Its operation was financed by the City of Louisville and a tax on goods sold at auction in Jefferson County.

In this milieu of national expansion, rapid growth of population, industry, and wealth, a concern for improvement of our social structures emerged. It may have been related in some manner to the "Great Revival" in religion which began in Kentucky about 1800, but it concerned two serious problems — slavery and alcohol abuse. Similar problems continue today to demand the attention of all citizens in seeking solutions, although they have been addressed in various fashions by preceding generations.

Support for the abolition of slavery had been present in the Northern Colonies since the 1760s — voices mainly of Quakers¹⁴ and clergy of other denominations. At Kentucky's first two Constitu-

Current model anesthesia machine with automatic ventilator. CO₂ absorber, flow meters, calibrated anesthetic vaporizers and monitoring apparatus.

There are monitors for tissue pO₂ and for direct determination and read-out for pCO₂ and pO₂ in inspired and expired atmospheres. Others produce continuous systemic and pulmonary arterial and venous pressure traces synchronized with the ECG. Direct read-out of systemic arterial pressure at 10-second intervals plus body temperature determination appear on the oscilloscope screen or in the LED frame on the console. This is an example of "high-tech" in the practice of medicine.

The vignette is the equipment used for administration of anesthetics for the first century of anesthesia, 1846-1946.

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tional Conventions (1792, 1799), efforts had been made to abolish slavery within the state by the Rev. David Rice [1733-1816], himself a delegate to the first convention.¹⁵

As was true with the general population, the medical profession was divided in its sentiments concerning slavery, but a few members achieved notice for their activities in the abolition movement. Daniel Drake, MD, was the outspoken physician advocate in Kentucky and Ohio.¹⁶ His influence became nationwide when his carefully crafted and reasoned letters sent to his colleague and friend John Collins Warren, MD [1778-1856], of Harvard, were published in *The National Intelligencer*, Washington, DC (1851).¹⁷ These letters were lauded and highly recommended by his colleague and biographer, Samuel David Gross, MD [1805-1884].¹⁸

Although the great Kentucky statesman, Henry Clay [1777-1852], had succeeded in effecting legislation in the US Congress that became known as the Compromise of 1850, the respite from inflamed rhetoric and armed conflict was brief.¹⁹

Physicians for several centuries (13th to 18th) had acclaimed distilled spirits a divine product and called it "aqua vitae." As spirits became more readily available, many imbibers would become drunk and disorderly while others developed serious physical and mental disorders by their excesses. Physicians in England had even petitioned Parliament to increase the excise tax on spirits in a futile effort to curb consumption. Under the leadership of Benjamin Rush, MD [1745-1813], the Pennsylvania Assembly, and later the US Congress, was petitioned to impose similar taxes with the expectation of reducing alcohol consumption. Rush also published several papers in the public press on temperance that were widely circulated throughout the United States.²⁰ By 1826, a national temperance society was functional.

In March 1828, Daniel Drake, MD, was invited to present "A Discourse on Intemperance" to the Agricultural Society of Hamilton County, Ohio. Dr Drake considered himself a Kentuckian, and lived in Kentucky for much of his life, but he maintained a permanent residence in Cincinnati in his autumnal years. This lecture of Drake's was perhaps the first temperance lecture in the West. It was published in the *Western Journal of Medical and Physical Sciences*.²¹

There were temperance societies in nearly every community, and by 1841, one was active at

the Louisville Medical Institute. Drake organized a Physiological Temperance Society of which Lunsford Pitts Yandell, Sr, MD [1805-1878], was the first president. In 1847, it had 610 students and seven officers of the Institute as members.²²

The temperance movement gained momentum following the Civil War and remained a vigorous force well into the present century until the 18th amendment to the Constitution became effective, 16 January 1920 (one year after it was ratified). National prohibition lasted until 5 December 1933, with the adoption of the 21st amendment.

During most of the first half century of Kentucky's statehood, medicine had little scientific knowledge of disease etiology or of the precise response of the host to the disease process. Likewise, the physician had few drugs for specific treatment of disease.

Several specific drugs for therapy had been empirically discovered, and some had been in use for several centuries, eg, opium gum from *papaver somniferum*, for the relief of pain; the bark of *salix nigra* (US, Black Willow) or *Salix fragilis*, L. (European Crack Willow), as a febrifuge; *Digitalis purpurea*, for the treatment of heart failure; quinine or a decoction of *Cinchona* or Peruvian Bark (*Cinchona rubra*), for malaria.

The diseases treated with willow or cinchona bark were in reality symptoms, ie, fever. Although malaria as a quartan or tertian fever was well described, neither the vector nor the causative parasite was known until the late 19th century. *Digitalis* was known to "steady" the pulse in atrial fibrillation, but its use in heart failure was confused by a misunderstanding of the etiology of the peripheral edema; until the beginning of the 20th century, the drug was thought to have diuretic properties.

Medical men and natural philosophers struggled with the emerging sciences of chemistry and botany, searching for new, more effective medications for the ills of man and beast. Although active components of many botanicals, eg, morphine, codeine, quinine and many others had been purified, separated, and identified, organic chemical synthesis was unknown until Friedrich Wohler [1800-1882], in 1828, synthesized urea from inorganic constituents.²³

During this early period, Kentucky surgeons proved to be innovators and vigorous adapters of old and new techniques. Benjamin

Winslow Dudley, MD [1785-1870], of Lexington, and Ephraim McDowell, MD [1771-1830], of Danville, were foremost in the field of "cutting for stone" (bladder stone) and their fame extended well beyond Kentucky's borders.²⁴ Alban Gilpin Smith, MD [1795-1876], of Danville,²⁵ and Samuel Brown, MD [1769-1830], of Lexington,²⁶ struggled with the new technique of crushing bladder stones which had been devised and perfected by Jean Civiale of Paris, France (1824). By successfully removing a large ovarian tumor (1809), McDowell demonstrated for the first time in medical history that the peritoneal cavity could be safely opened. In 1817, he published the results of three such cases.²⁷ Dudley, in 1828, described a surgical treatment for post-traumatic epilepsy, but it remained an isolated advance until the concepts of antisepsis and asepsis were formulated over a half-century later.

Following the great social and financial upheaval caused by the Civil War in our country and the war in the Crimea in Europe (1853-56), many advances in medicine and science were made.

In 1860, the disproof of the ancient concept of spontaneous generation and the following year, Louis Pasteur's proof of living organisms in the air²⁸ marked the beginning of a new era which changed medicine from empiricism to science. Pasteur's work produced the modern theory of inoculation against disease and Robert Koch, MD [1843-1910], demonstrated that disease was caused by a specific organism — first, in his work with the anthrax bacillus (1876) and later, with the tubercle bacillus (1882).²⁹

Knowledge now accumulated rapidly in Bacteriology, Immunology, and Pathology as a result of researches in the laboratories of medical schools of the western world. Application of this knowledge to the welfare of Kentuckians was achieved by the medical profession, the medical schools and a new partner, The State Board of Health.

During the first term of Governor James B. McCreary [1838-1918], in March 1878, the State Board of Health was established. Kentucky was one of the early states to have such a Board. Governor McCreary appointed five physicians, one of whom was chosen President of the Board. He was Pinckney Thompson, MD [1828-1897], who served with distinction for 15 years.³⁰

Our only physician-Governor, Luke P. Blackburn, MD [1816-1887], succeeded Governor

McCreary in 1879. Governor Blackburn made two outstanding contributions to our Commonwealth. The first was his effort to reform the penal system in the state by emphasizing rehabilitation rather than punishment, and, as part of this program, he began construction of a new modern penitentiary at Eddyville. His second contribution, and perhaps his most significant for the health and welfare of Kentuckians, was his appointment of Joseph N. McCormack, MD [1847-1922], to the State Board of Health (1879). In 1883, Dr McCormack was made Executive Secretary of the State Board of Health. During his service in this capacity until 1913, he is said to have written all of the laws of the state dealing with public health, medical education, and the practice of medicine.³¹ The State Department of Health, under the leadership of McCormack, and later his son, Arthur T. McCormack, MD [1872-1943], was an effective and much respected department which was dedicated to promoting and protecting the health of our citizens. The new Constitution of Kentucky (1891), as poor and restrictive as it has become, made it possible for the legislature, under the guidance of J. N. McCormack, MD, to give a new range of authority to the State Board of Health. A number of Bureaus were established including one for Sanitary Engineering, others concerned with the inspection of food, drugs, hotels, housing, and departments for bacteriological, immunological, and pathological studies.³²

Citizens of Kentucky had suffered high mortality from water-borne diseases, ie, cholera, typhoid, and bacillary dysentery, but by the end of the century, public health measures and specific inoculation against these diseases had eliminated cholera and greatly reduced the morbidity and mortality of the others. Public health quarantine measures had controlled the epidemics of exanthema: chicken-pox, rubella, and roseola. Diphtheria epidemics were controlled by quarantine, and morbidity and mortality were much reduced by antitoxin administration. The State Board of Health and its county health officers, working in cooperation with the local physicians, made life a little less troubled by contagious diseases. The Spanish Influenza of 1918-1919, caused the State Board of Health to impose severe restrictions, and they administered over 10,000 doses of a new anti-influenza vaccine.

During the 1937 floods, in river towns throughout Kentucky, the medical communities, with the assistance of a strong state Board of Health, safeguarded the health of the communi-

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ties by vaccination of the affected populace against typhoid.

The Jefferson County Department of Health and physicians of the Jefferson County Medical Society, with 12,000 volunteers, in October 1962, coordinated oral vaccination against polio in Jefferson County.³³ Less inclusive vaccination programs were later conducted throughout the state.

Technology assisted in advancing medical science early in the 20th century when ECG equipment became available, better lighting in closed cavities and in operating rooms assured good visualization and accuracy of the operating surgeon, x-ray equipment became more sophisticated and radiation dosage became better understood. Better steam autoclaves were developed for sterilization of equipment and intravenous solutions.

World War II introduced the physician to pre-packaged intravenous fluids and dried plasma as well as "A" and "C" rations and all sorts of portable equipment from OR lights and x-ray equipment to metal detectors. Air evacuation of the seriously injured originated in the military and was later to be adopted for rapid evacuation of those injured in traffic, industrial and other accidents, and emergencies.

Following World War II, there was a virtual explosion of technical developments, and these advances were added to from civilian sources and the space program, as well as military developments for medical support of men in Korea and Vietnam.

Expanding technology fostered physiologic trespass. Surgeons began inserting fingers and knives into the beating heart in 1949-50, to relieve the restricted flow of blood through a damaged valve (mitral). Other pathologic conditions needed attention, which called for additional knowledge and additional trespass to allow surgical correction.

Machines were developed that oxygenated and circulated the blood, allowing the heart to be stopped and repaired inside or outside. More sophisticated electronic apparatus was developed for tracking the nerve impulse inside the heart (in the Bundles of His, Keith, or Kent or any pathway in the myocardium which may require surgical interruption) to assure better cardiac function free of troubling rhythms caused by re-entry of the normal impulse through an aberrant pathway.

The old threat, first described by the Irish

physician Robert Adams, in 1827, and later, 1846, by another Irish Professor of Medicine, William Stokes, MD [1804-1878], and now known as Stokes-Adams Syndrome, is caused by temporary atrioventricular heart block resulting in a cessation of blood flow. This can now be effectively managed by the implantation of a pacemaker, which is a miniaturized electronic apparatus with self-contained, long-term batteries. In Kentucky, apparently the earliest such implantation was done by Daniel E. Mahaffey, MD, at the Kentucky Baptist Hospital in January, 1961.³⁴ At present, the pacemaker also incorporates an automatic defibrillator.

Advancing technology has allowed miniaturization of many older equipment designs so that their range of application is expanded.

Another "physiologic trespass" was to eventually develop into a subspecialty — nephrology. Dialysis of the blood was initially attempted to aid in the treatment of patients with temporary renal shut-down caused by the ingestion of toxic chemicals or severe shock. From an early exchange apparatus consisting of a length of sterile cellophane candy wrapper, physiological saline solution, and a pressure cooker (1950), extracorporeal dialysis apparatus has evolved into sophisticated, safe equipment for dialysis of patients suffering from chronic renal failure. Centers providing this service are now located in most of the larger cities of the western world.

Fiberoptics, an outgrowth of our space program, has allowed us to see better inside cavities previously visible only indirectly or with dim incandescent light; for instance, we can put a cool light source inside the eye or on a long flexible cable to visualize the entire length of the large and small gut. We may then project the image on a TV screen, make a video tape, or take serial photographs.

Sophisticated optics made of a light plastic have made magnification available in the operating room and office. This has allowed surgeons to see better and operate on smaller and smaller structures which resulted in a demand for better sutures. Now several new synthetic suture materials are available that have strength and flexibility while only 100 microns thick.

Advancing technology has given us new and better instruments, diagnostic equipment, and apparatus that destroys renal calculi without leaving a scar or an incision. Other instruments allow performance of major surgery through puncture

wounds instead of long, painful incisions. New plastics and metal alloys for making new joints or new blood vessels readily reached the marketplace.

Technology has advanced so rapidly from 1950 to 1990, that we have been able to progress from the finger-fracture of stenosed mitral valves to open-heart and coronary bypass surgery, to heart transplants, and even extracorporeal mechanical hearts.

When Transylvania University Medical Department in Lexington closed in 1859, Louisville became the only center for medical education in Kentucky. In the age of proprietary medical schools, there were as many as five medical schools teaching students in Louisville at the beginning of the 20th century. This does not include four or five short-lived schools espousing the teaching of other systems of medicine in the late 1840s and 1850s, nor does it include the Louisville National Medical College founded by (William) Henry Fitzbutler, MD [1842-1901], which successfully functioned in Louisville, 1888-1912, and was specifically for African-Americans.³⁵

Before the Flexner Report, consolidation of the remaining medical colleges in Louisville had begun, and by 1908, all five schools had joined the University of Louisville Medical Department. They were the Kentucky University Medical Department (1907); Hospital College of Medicine and Louisville Medical College merged in 1907, and in turn, merged with UL the following year; and The Kentucky School of Medicine (1908). For nearly half of a century, the University of Louisville School of Medicine was the only medical school in the state of Kentucky. This was changed in 1954, when it was decided that a medical center should be added to the expanded post-World War II campus at UK, Lexington. The legislature funded the venture and under UK President Frank C. Dickey, the first dean, William R. Willard, MD [1908-1991], was appointed in 1956. He oversaw the making of the medical center and the gathering of the faculty. The first class of students entered in 1960, and when they began their clinical training in 1962, the hospital was complete.³⁶ Now Kentucky has two medical centers — one in Lexington and one in Louisville. Both schools have benefited by having another faculty group with which to share ideas, problems, and faculty.

Medical practice standards were much improved in Kentucky when medical practice laws were enacted in 1888, 1898, and 1908. Medical

Licensure was administered under the State Board of Health. Graduates of foreign medical colleges (FMG) could not be fully licensed to practice in Kentucky under the laws in effect until 1972. FMGs could practice under a limited license, ie, their practice was restricted to state psychiatric or tuberculosis hospitals or under the supervision of university medical school programs. In 1972, the first Medical Practice Act to establish a separate Board of Medical Licensure was passed. Since this time, Kentucky citizens and the medical community have benefited from the knowledge and talents shared by a host of physicians trained in all parts of the world.

It is apparent in this review that the patient, although receiving much more accurate diagnosis and far more effective therapy than could possibly have been imagined 200 years ago, has had the physician distanced from him/her by technicians and specialists who must use and interpret the "high tech" diagnostic and therapeutic materiel at hand. Both the physician and the patient must strive to maintain physician-patient relationships despite the size of the gulf thus produced. But, these are not the only threats to the physician-patient relationship, for here the third party payor looms large, be it a private insurance carrier or a government reimbursement program. This is perhaps a greater obstacle than "high tech."

The medical profession has been an integral part of the state since Kentucky was a Court District of Virginia consisting of three counties. Its contributions to the health and well-being of our fellow citizens have been numerous, and when one of us steps out of line, it is perhaps proof we, too, are human beings in spite of the occasional miracle it may appear we have wrought.

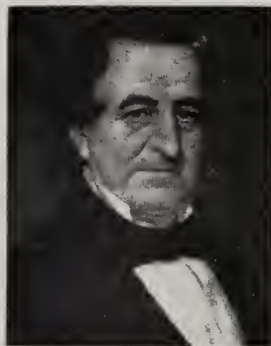
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ADDRESS BY THE PRESIDENT
of the
KENTUCKY STATE MEDICAL SOCIETY
William Loftus Sutton
Georgetown



William Loftus Sutton was born near Georgetown, Kentucky, on 21 May 1797. His early education was obtained at the Rittenhouse Academy, Georgetown, and his classical studies were pursued at the Bourbon Academy in Paris, Kentucky. In 1815, he became the private pupil of Dr. Richard Ferguson, a prominent Louisville physician, in whose "shop" he studied almost two years. When the Medical Department of Transylvania University was organized in 1817, young Sutton matriculated and thus became a member of the first class of the first medical college west of the Allegheny Mountains. Following the course of lectures he felt competent to practice medicine and accordingly opened "shop" at Catlettsburg, Kentucky.

The Medical Department of Transylvania University was suspended in 1818 and "Dr." Sutton went to Baltimore where he was graduated M. D. from the University of Maryland on 5 April 1819. His thesis was entitled, "Absorption." He returned to Catlettsburg where he practiced until 1820 when he moved to Morganfield. Here he remained thirteen years and then permanently located at Georgetown.

Dr. Sutton was one of the most influential physicians in the formation of the Kentucky State Medical Society as has been mentioned elsewhere. Another important service to Kentucky was his successful advocacy of a vital statistics registration act before the Legislature in 1852. The writings of Dr. Sutton comprising five books, forty-five essays and seven annual reports on vital statistics to the General Assembly reveal wide knowledge of all branches of medicine. His major interests were in the fields of public health work and vital statistics. In 1846, he received a prize of Fifty Dollars from the Medical Society of Tennessee for an essay on "Scrofula." He was an early and active member of the American Medical Association and its First Vice-President in 1858-59. Before this Association, he made many reports concerning vital statistics and epidemics in Kentucky and Tennessee. The presidential address of Dr. Sutton which follows deserves reprinting not only because it was the first one delivered but also because of its timely admonitions and thoughtful discussion of the duties of physicians to each other, to their patients and to the community at large.

Were space available much might be said of his kindliness, his sincerity, his active Church affiliation (Presbyterian), his community spirit while Chairman of the Board of Trustees of the City of Georgetown, and of his happy family life. Dr. Sutton died at Georgetown on 20 July 1862. (The portrait above was painted in 1852 by S. T. Bancroft and is used by permission of Mrs. Brice Goldsborough, a granddaughter.)

Being altogether unaccustomed to public speaking, in attempting to deliver this address before the Society—containing many of the most talented medical men of the State—I manifest a most unequivocal evidence of my devotion to our profession, and respect for the wishes of the Society, as expressed at the former meeting.

At this meeting, which may be considered the commencement of our labors, it is both natural and proper that we should calmly enquire what it is which we propose to do: and the best means of doing it.

Our Constitution declares our object to be: 1st. The establishment and maintenance of union, harmony and good government among its members; thereby promoting the character, interests, honor and usefulness of the profession. 2d. The cultivation and advancement of medical science and literature, by the collection, diffusion, interchange, preservation, and general circulation of medical knowledge throughout the State.

I shall therefore confine myself to a limited consideration of two points: *first*, our duty to the profession; *second*, our duty to the community in which we live. In doing this, I do not presume that I shall say anything which is not perfectly familiar to every gentleman here: nor say it any better than any one here would say it. But, for mutual improvement: "as iron sharpeneth iron, let every man sharpen the face of his neighbor."

It is our duty to the profession that we hold it and the members thereof, in the highest honor. The profession is eminently entitled to honor and respect, because it has for its object the most important and momentous subjects appertaining to this world—the life and health of each individual, and the general health of the community.

It is entitled to honor because of the purity of conduct and uprightness of character of the bulk of its members. It is entitled to honor and respect because of its expanded benevolence and extensive charities.

But we must not be content with honoring our profession ourselves: we must cause others to honor it likewise. How much so ever we may understand and appreciate the foregoing considerations, we

shall find very few that can do it.

We should require a suitable compensation for our services, and require it to be paid promptly, both by individuals and corporate bodies. Such has been the liberality (if I may call it so) of our profession, that public bodies and even individuals many times think that they confer an honor on a physician by employing him, without troubling themselves about making any compensation; or at most, fixing, themselves, the compensation after the services have been rendered. Thus I have known the trustees of a town, upon the appearance of smallpox in it, direct certain physicians to use all diligence in vaccinating all persons susceptible to the disease. After these physicians had used great diligence, successfully vaccinated the inhabitants, and prevented any case appearing out of the family first affected, I have seen the trustees dock their charge sixty-six per cent, on the plea that many physicians vaccinate gratuitously the families which they usually attend. And what is worse, I have seen the majority of the physicians quietly submit to the treatment. Many similar examples might be adduced. This is all wrong. If a man does not respect himself and his profession, he need not expect others to respect either.

But, the profession is made up of individual members. It can be honored and respected only in *their* persons. It is perfect nonsense to talk of honoring the profession, whilst we speak disparagingly and disrespectfully of its members. If we, by words direct, or by innuendo or dark hints, suggest that this, that, and the other physician is a mere pretender—scarcely fit to treat the most simple diseases, we have no right to complain if he treats us in the same way. The result of all of which is, that the community will believe much that is said to the disparagement of each, and the whole lot of physicians lose standing. Of course, individually and collectively the profession is not respected—it *cannot be!*

So far should a physician be from indulging in these petty slanders, that he should not suffer his acquaintances to speak disparagingly of other physicians in his presence. Many men will aim to ingratiate themselves with one physician by speaking slightly of another. We ought always to reflect that what Horace wrote, nearly two thousand years ago,

*Delivered before the Second Annual Meeting of the Kentucky State Medical Society, Louisville, October 20-22, 1852.

*... Absentem qui rodit amicum
Qui non defendit, alio culpante ...*

Hic niger est: hunc tu Romane caveto. is still true. We should not only guard against traducing our brethren, but we should, to the utmost of our power, discourage it in other men. Must we speak falsely to shield a brother? By no means. A man, even a highly respectable man, may do something very wrong which the public good requires should be exposed. No man ought to shrink from what his duty requires. But in the thousands of petty difficulties which occur, we should be very guarded in expressing an opinion unfavorable to a brother: especially when it is predicated, as nine times in ten is the case, upon one-sided statements and those of parties interested. Not only so, but we should suggest such palliating circumstances as present themselves to our minds. We may safely believe that the man who most scrupulously guards his own conduct, will be most ready to palliate what seems to be wrong in another.

It is no excuse for failing to pursue the course above indicated, to say that the physician implicated has more reputation than he deserves. He is in the way of my advancement: he is overbearing and dictatorial in his intercourse with his brethren;—or any thing of that kind. Every physician ought to be willing, and to expect, to stand upon his own qualifications, and not to succeed upon the want of qualification in his competitors. If he has failed to impress upon the community the due appreciation of his merits, he should consider it as his own misfortune and not the fault of his more successful competitor, even though less qualified. He will have the consolation too of knowing that many highly qualified physicians have experienced a like neglect.

If any member of the profession, from any cause, is disposed to place himself above his fellows, it is a duty which they owe to themselves and to the profession to resist such pretensions; and by a firm, decided, but still respectful course of conduct, convince him that his claims will not be allowed. In one word, we should feel that we ourselves are gentlemen, and should always acknowledge others as gentlemen until they forfeit the title by improper conduct.

Perhaps nothing tends more to the honor and high estimation of the profes-

sion than the organization of State, District and County Medical Associations. These promote the usefulness of the profession in two ways. Men associated for scientific and benevolent purposes must of necessity improve each other. As they become acquainted with each other more intimately, they must see various points of attraction in each. They may have warm debates, but each will perceive that his opponent has better ground for his opinion than he had been aware of; objects will be presented in new points of view; some excitement may take place at the time, but that will soon subside and be replaced by an increased respect and warmer friendship. Again, view the beneficial effect produced on the community. It is impossible that any people can be aware that an association of men meet regularly for mutual improvement, without having an increased respect for them, as a body and as individuals. This respect will be still further heightened by the increased cordiality and good feeling, which are seen to exist between the members of the Association.

It is within the knowledge of many now present, that the profession as a body, and physicians as individuals, are less respected now than they were thirty years ago. Why is this?—Several causes conspire to produce the effect, some of which, only, I shall notice. Thirty years ago a graduate in medicine was considered as necessarily a gentleman of education. Indeed many gentlemen of education, and who had complied with all the conditions requisite for a degree, had such an awe of an examination for the honor, that they shrank from the perilous trial. Hence to have graduated was in truth an honor. But how is the matter now?

In those days the number of physicians was not greater than the population required. Now the whole country is crowded with physicians, armed with diplomas. It may be well to look for a moment at the proportion of physicians to the population in Europe, and in this country. In Switzerland, with a population of 2,150,000, there were 450 graduated physicians, at the last census: [Welford's *Address*.] In France, with a population of 35,000,000, there are from 18,000 to 20,000 physicians, including officers of health: [Boston *Med. and Sur. Jour.*, July 14th, 1847], or 1 to 1,750 inhabitants. In the United States, with 20,000,000 inhabitants, there are about 40,000 physicians.

Again, in France, there are 1800 medical students and from 300 to 700 graduates annually; in the U. States 4,418 students and 1,300 graduates: [*West. Jour. Med. and Sur.*, V. 8: p. 414.] In Kentucky, according to the late census, there are 982,405 inhabitants and 1470 physicians: or 1 physician to 668 people. Again, in London there is 1 physician to 800 people; in Paris, 1 to 662; in New York, 1 to 500: [*Trans. Am. Med. Ass.*, V. 2: p. 344;] and in Memphis, 1 to 176! [*Grant's Vital Statistics of Memphis.*]

What is the cause and what the effect of this repletion of the profession in the United States? The cause is, the disgracefully low requirements for entering the profession, and for graduation. The effect is that men are ushered into the profession, so far as academic honors are concerned, whose mental training has been next to nothing—whose professional knowledge is such, that for their lives they cannot tell whether or not a woman has a prostate gland—cannot distinguish a prolapsus from retroversion of the uterus, or an abscess from a tumor or a hernia; yet they are placed upon a perfect footing with the best qualified. These men, having spent little of either time or money in the acquisition of knowledge, are sometimes satisfied with the pay which their services are worth. If the matter ended here it would be well. But, the services of those who have spent both time and money in the acquisition of knowledge, are estimated at the same value. Nothing is more common than for a patient to complain of a bill, because Dr. So-and-So charged less for similar services. Men can very well understand why one yard of cloth costs more than another, but cannot understand why one physician may rightfully charge more than another. It is said that competition is the life of trade. It is all very well within certain limits. But, when more goods are manufactured than can be consumed, the value of each parcel is lessened, and some must remain unsold. The best samples, being higher priced, must first be driven from market. This is a great and a free country: the people have the "inalienable right" to choose a *regular physician*, an *eclectic*, a *homoeopathist*, or a *hydropathist*;—one who is satisfied with fifty cents per day for his services, or one who thinks his services worth five dollars; but, surely, we who profess to understand the value of human life and human health—

who know in how many ways the life and health of our fellow men are put in jeopardy and destroyed by incompetent medical advisers—surely we ought not to lend our aid in introducing inferior articles into the market. On the contrary it is our duty, and we ought not to shrink from it, to impress upon our friends a proper view of this momentous subject.

We should support the honor of the profession by a free intercourse with its members. In a widespread country, this can be done only through the medium of our periodicals. With commendable professional pride, two medical journals have been established in this city, but are they sustained in a manner at all commensurate with the wants of the profession? It is objected to the journals that they are filled by writers who have little experience, and whose suggestions are of little value: that they are altogether trashy and unprofitable. One of the easiest things in this world is to find fault. It is true that there is much trash in all journals. From the nature of things it must be so. Yet, every now and then every journal contains a paper, which, of itself, is worth to a reflecting mind, more than a year's subscription. But grant that a whole year passes and nothing new is produced, is the journal, therefore, of no value? If no new subjects are introduced, old ones are presented in aspects more or less new. But even if no subject is presented in a new aspect, still the journal has its value. If it does no more, it renews and enlivens impressions upon subjects of former study, which were becoming faint and indistinct. It is not sufficient that we have learned important facts, and established important conclusions, we must keep them fresh in our minds, that they may be made available in the hour of need. This can be done only by recurring to them frequently; revolving them in our minds, and observing their bearings upon related points of investigation.—The more we converse, read and reflect upon any subject, the better shall we understand it. But, if after studying a subject even thoroughly, we dismiss it from our minds, and cease to reflect upon it, we will soon forget nearly all we had learned. We should after no long time forget the names of our most intimate associates, if our intercourse of circumstances did not cause us to recur to them at intervals. The air which we breathe, the source of life, health and vigor becomes, by stagnation, the source

of debility, disease and death. To keep it in a health-giving state, it is necessary that it should be agitated continually by winds, and occasionally by a storm or hurricane.

But what have our fault-finding brethren done to improve the condition of our profession? A large majority never took a journal: and perhaps nineteen in twenty never contributed an article to a journal in their lives. They surely might have some charity for the puerilities of others, until they have demonstrated that *they* can do better. Journals must be supported by subscriptions and by contributions. The subscription list is small: the contribution list vastly more so. I have looked over the *Western Journal of Medicine and Surgery*, and find that during the year 1851 *ten* gentlemen in Kentucky, besides the Editor, contributed to its pages! Why is this? Why do not the physicians of Kentucky give to the world the results of their observations? Say that an equal number contributed to the *Transylvania Journal*, and we have *twenty* for the whole State. I repeat, why is this? The excuse ever ready is, "the press of professional engagements" — "entirely too busy" — "have not the time!" Gentlemen, it will not do. Make your excuse "want of disposition," "want of ability," or the want of anything but "time." In the name of God, do not slander our country by saying that of 1470 physicians in the State, only twenty have time to contribute something to a journal annually. We all have our "anomalous cases," and our "astonishing cures," which we love to rehearse in the ears of our kind and credulous friends: why not lay them before those whose judgment is worth something: whose good opinion will confer honor?

But, grant that young men write for the journals, and even that they are prompted by an overweening vanity to write: still we have good results. No man can write down an essay upon any subject, without understanding more about that subject when he is done, than he did when he began. So then if he has taught no other man, he has taught himself. So true is this, that if a man wishes to understand a subject thoroughly, one of the very best things he can do is to write an elaborate treatise on it.

2. *Our duty to the public* necessarily involves, to some extent, a corresponding duty to the profession.

It is our duty to protect the community against the evil effects of quackery, in all its forms. Of all our duties, I do not know one more important, more difficult, or one for which we will be more certainly censured. If we speak of a quack as his conduct merits, instead of gaining credit for honesty, philanthropy, and a desire to preserve the health and lives of our neighbors, we shall be considered censorious and jealous of superior merit. If these censures were bestowed by the illiterate and ignorant alone they might be borne, with the aid of a little philosophy; but when well educated and refined gentlemen, men of standing and influence in society, become active partisans of quacks, it is humiliating. What then shall we say when respectable, nay eminent, men in the profession, not only countenance such characters by associating with them, but give them certificates to favor their impositions in remote regions of the country?

But how shall we conduct ourselves toward quacks and quack medicines? If a man is disposed to tamper with a quack, and we show him conclusively the folly and absurdity of his intention, we make him our enemy, and only strengthen his determination. When a man has once made up his mind to do an absurd thing, he will always find sufficient reasons to justify his conduct in his own eyes;—like the Editor of a certain respectable paper in this city, who had never admitted a quack advertisement into his journal, until convinced of the pre-eminent virtues of "Ayer's Cherry Pectoral." But in what that differs from other quack medicines, neither he nor any body else can tell.

In my opinion, we should not, by any act, countenance any of the tribe. In promiscuous conversation, we should decidedly express our abhorrence of the whole system. I doubt whether any good will come of denouncing any particular individual who happens, for the time being, to be the favorite. When asked why physicians do not directly oppose such persons, and convince the public of the danger to which they expose themselves by following such pretenders: my answer has been, "I have been practicing medicine now thirty years. Every body knows, or might know, that I have ever set my face against all such things: why should I embroil myself with the partisans of every knave who passes through the country? They will consider me as actuated by no higher

motive than that of putting down a man who is in my way." I am in favor of letting them stand on their own merits, without giving a prop, found in, what will be called, persecution.

Another duty to the public is, to use all proper means to secure to them a succession of well instructed physicians. This duty is divided between private practitioners on the one hand, and medical colleges on the other; and like many cases of divided responsibility, each party frequently fails to discharge its own duty, and attempts to throw the blame upon the other. The practitioner says he has nothing to do with conferring degrees, and is in no way responsible for the character of the graduates of any school. On the other hand, the colleges say, we have no hand in the reception of students, or in their early training; we must receive such students as are sent us, and finish their education the best we can. Literally, *perhaps*, both speak the truth, but in fact it is not so. It is true that the private physician has nothing to do in the act of conferring a degree in a given case. It is also true that when a degree is conferred upon an unworthy recipient, the college ought to bear the responsibility. Yet, it is true that the standing of the graduate, is, and ought to be, joint-stock between the private preceptor and the college. If he is a worthy physician, both have cause for gratulation; if unworthy, both should feel humbled.

The private physician should resolutely refuse to receive into his office for instruction, any young gentleman whose natural intellect, moral character, and previous academic training, do not afford reasonable grounds to believe that he will make a respectable member of the profession. Having received a student, he should indeed become a *tutor*; he should examine him upon his studies at stated times: explain what he does not comprehend, and see that his ideas are clear and definite upon all points.—He should take his student to see his cases, explain the import of symptoms; the reasons governing diagnosis and prognosis; and why the particular prescription made is suited to that particular case. He should also see that his student can put up prescriptions in a decent and creditable manner. When the student is about to attend college, his preceptor ought to give him a certificate stating his age, moral character, previous literary acquirements, and the period of

his pupilage. In this age of progress, the student will be very apt to attend whatever college he may find most convenient; still it is the right and duty of his preceptor to lay faithfully before him all the reasons why he should attend or avoid any one.

It is likewise true that colleges have not the reception of students in the first instance, and that they must instruct such students as are sent to them. But it is by no means true that they must confer degrees upon those not qualified to receive them.

Our colleges generally have lists of requirements of candidates for a degree. Those requirements are low enough in all conscience. Nevertheless, degrees are sometimes conferred without those requirements being complied with, either in letter or spirit. I have known a young man with a very ordinary education, leave a mechanic's shop on the 1st of November, and on the ensuing March twelve months, receive his diploma. Nay, worse than this: during the present year, I heard of a young gentleman who commenced his medical pupilage at the beginning of a summer course of lectures, and received his diploma the ensuing spring. It is fair to presume that the colleges, concerned in these and such instances, did not know that their requisitions had been evaded. But *they ought to have known it*. There is no use in making rules and paying no attention to the observance of them. If our colleges should do these things, and practitioners remain silent, what right have we to complain that the people favor Homoeopathy, Hydropathy, or any other "pathy?" With what grace could we anathematize steam doctors, root doctors, or any other pretended doctors? If our colleges should pursue this course, that would be a justification to induce physicians to advise their pupils to attend such schools as are more particular in bestowing their honors.

We cannot put down irregular practitioners by calling them hard names. We cannot, and we *ought not*, to maintain the superior position which we covet, but by superior knowledge, intelligence, skill and virtue.

An important duty which we owe to the community is, that we take the lead and instruct the public mind, preparatory to introducing sanitary regulations into our Commonwealth. All the attention

which our Legislature has paid to the lives and health of its citizens, consists in the enactment of a very few sections respecting small-pox, which have long since been forgotten, and never were of any avail. Any man or body of men, who neglects a known duty, incurs a guilt, for which he or they will almost certainly be punished in some way or other. No one will deny that one of the most important duties of a government is to preserve the life and health of the people. If any government neglect that duty, it will be punished in the form of sickness and death, prevailing to an undue extent among the people; or of a debilitated and inefficient population, in which filth, poverty and crime will be rife; and in which religion, morality and life will be equally disregarded.

As our legislators have thus far paid no attention to the public health, it becomes our duty to endeavor to awaken them to a sense of theirs. We may reasonably suppose that they will not turn an ear altogether deaf, to the suggestions and admonitions emanating from a body as learned, disinterested, and philanthropic, as the Kentucky State Medical Society promises to be.

Our State is yet young;—we have no overgrown cities. It is an old adage that an ounce of prevention is better than a pound of cure. Now, therefore, is the time to engraft on the charters of our towns and cities, provisions which shall forever prevent the citizens thereof from being cursed with narrow streets, closed up courts, subterranean dwellings, etc., where the sun never shines and the wind never blows; which shall compel cities as large as this, to have spacious avenues, large open public squares, plentiful supplies of good water, sanitary police, and many arrangements for the purpose of securing health and promoting longevity.

In many portions of this Commonwealth, we have almost forgotten that there is any danger to be apprehended from small-pox, whilst we are actually in greater danger than we ever were. The time has come when a man may contract the disease in almost any portion of the Union, and break out with it in the interior of Kentucky. To exemplify the carelessness and danger upon this head, I will relate an anecdote within my own personal knowledge. Some years ago, a physician with a large family, removed to

Georgetown. Having learned that more than twenty of his family had never been vaccinated, I took the liberty of calling upon him, and urging upon his consideration the prompt attention to that duty. Of course he acknowledged the propriety of doing so, and promised compliance. Several months afterwards, I learned he had still neglected it. Thereupon I procured some virus, gave it to him, and again urged immediate vaccination. Again he promised, and again neglected it. A few months after this, he was called to see a gentleman who had lately arrived in town, having an eruption upon him, the precise nature of which was not determined. A short time after, his wife was seized with a violent fever, which, after a few days, was followed by a very profuse eruption. Upon consultation the disease was determined to be confluent small-pox. He now had the felicity of realizing that, for the last two weeks, he had been attending a case of varioloid, and more recently, one of unmodified small-pox, without suspicion or precaution, with twenty members of his family liable to be seized at any moment! It is utterly impossible for any one who has never been similarly situated to realize his reflections.

It becomes this Society to consider what means may be legally and properly brought to bear upon the people of this State, to induce them to protect themselves against this loathsome and fatal distemper. There are measures, having for their object the preservation of health, too numerous to be mentioned in this address, upon which we ought to instruct the people, and suggest means by which they may be made beneficial to the community.

There is another subject upon which the influence of the profession ought to be exerted. Those who have paid any attention to the manner in which coroners' inquests have been conducted, cannot fail to feel that a vast improvement is imperiously called for by the public good, whilst our present condition promises nothing but a greater deterioration. To any one at all conversant with the subject, it is evident that no one but a lawyer or a physician, or at any rate a man of much judgment, prudence and general information, should be entrusted with the office of a coroner. It is doubtful whether in the one hundred counties of the State, one such man holds the office. As this

officer is elected by the people, I know of no remedy but by labor and perseverance, to enlighten the public mind upon this point.

I feel that I have taken up entirely too much of the time of this Society already, but I am not willing to close this address without alluding to a subject of much importance to the community and to the profession. In every county of this State, there is a considerable portion of the population who are utterly unable to pay for medical attendance. In some counties, some scanty provisions are made by the county courts, which, under certain restrictions, usually too onerous to be complied with, provide trifling compensation to physicians for attending such cases.— But almost universally, the physicians attend such cases without the most remote expectation of any compensation. This is many times coupled with the necessity of supplying medicines, diet, and even articles of dress, necessary to the comfort of their patients. This involves an outlay

of time and of money on the part of physicians, who usually are little able to bear it, and is altogether unreasonable; and to which burden no other class in the community has an equivalent, or any thing like it.

This Society ought to mature some plan of general application, by which a large portion of this burden may be removed from the shoulders of the profession, and urge it upon the Legislature for adoption.

As we admit no profession to be more useful or honorable than our own, save only that which points the way to eternal life, may I not, in conclusion, express the hope and conviction, that as a body and individually, we shall be ever ready to do all that in us lies, to aid that noble class of men in improving the moral, as well as the physical, condition of man; and, by impressing upon our fellow men a due sense of their obligations to one another and to their God, make them better citizens here, and fit them for everlasting life hereafter.



Samuel Alvin Overstreet, MD [1896-1986]

The following is Dr Overstreet's Presidential Address delivered at the Centennial Banquet of the Ephraim McDowell Memorial meeting of KMA in Louisville, October, 1951. It is reprinted here, for it provides some of the insights of a seasoned practitioner and the perspective gained during long service in both the Jefferson County and the Kentucky Medical Association.

This address, of course, does not tell of Dr Overstreet's contributions to his beloved profession, and I shall not attempt to list them; however, I would mention the monument to his vision for the future. He saw the building at First and Chestnut Streets, Louisville, that had been a medical school since its construction, as an historically significant building well worth preserving. Fortunately for the rest of us, he envisioned a manner in which graduates and members of the medical community could preserve it and keep it as a focus of medical society activity in the present medical center complex.

The mechanism for acquisition became the Medical Foundation of JCMS of which he was a founder and served as its first President, 1958-1982. The preservation and restoration of this building and the Medical Foundation of JCMS are indeed lasting monuments to Samuel A. Overstreet, MD.

— EUGENE H. CONNER, MD
KMA HISTORIAN

GOLDEN SPIKES*

Samuel A. Overstreet, M. D.

Louisville, Ky.

Dr. Samuel Alvin Overstreet, M. D., was born at Camp Nelson, Kentucky, in 1896. He was graduated A. B. from Asbury College, Wilmore, Ky., in 1918. Immediately after graduation he entered the U. S. Marine Corps in which he served until after the Armistice. He received his M. D. degree from the University of Louisville School of Medicine in 1923. Following a brief internship at Bellevue Hospital, New York, he was appointed Senior Interne at the Louisville General Hospital where he became Resident in Medicine (1925-27.) Dr. Overstreet began the practice of medicine in Louisville and at the same time received a teaching appointment with his Alma Mater. He is at present Clinical Professor of Medicine. During World War II, he was commissioned Captain, MC, US Naval Reserve. Dr. Overstreet is a Diplomate of the American Board of Internal Medicine (subspecialty: gastro-enterology), an active member of the American Gastro-Enterological Association and a Fellow of the American College of Physicians.

One hundred years ago our country was confronted with two major problems; the questions of slavery and transportation. The prolonged and bitter dissensions eventually leading to war and the tragic after-years that intervened before our nation was again truly unified are known only too well by all. Our population then was 23,000,000. Expansion by sea and overland trail had spread these Americans thinly from coast to coast, and from the sparsely settled Canadian border to the Gulf and the Rio Grande. The industrial East with its rapidly growing factories and railways was separated from the sprawling and fabulously rich West with its mining and railways by the Rocky Mountain barrier over which commerce dribbled in snail-like fashion by mule train and covered wagon. San Francisco was, by sea 30 days voyage from New York—via Cape Horn, an expensive and treacherous passage.

Practical dreamers, buccaneering industrialists, ingenious Yankees and western pioneers in true American fashion counselled and connived with the master politicians of the day and came forth with a vision of a transcontinental railroad. The realization of this dream is one of the most fascinating and romantic chapters in our history. To T. D. Judah, a young civil engineer in California, and Dr.

Thomas Durant, a restless young physician of New York turned to railroad construction, belong most of the credit for personally forwarding the endeavors leading to accomplishment of this plan. An Act of Congress was signed by President Lincoln in the latter part of 1862, authorizing the construction of a transcontinental railroad by the Union Pacific Railroad Company of New York and the Central Pacific of California. Civil war was then in progress. Dr. Durant devoted his time to the Union Army as a military surgeon, and surveys and construction were delayed. The American people had caught the vision of industrial development dependent upon improved transportation, however, and with the cessation of hostilities on the battlefield turned quickly to peace time development and a united nation.

Intrigue and treachery, boondogling, waste and embezzlement on a scale thus far unknown were combined with courage, privation and dauntless devotion to service. Personal dissention disrupted their leaders, unfaithful trusteeship and biased judgment depleted their treasuries and political pressures led their surveys along impossible routes only to be abandoned at huge cost of money and time; but to a few there was no thought of faltering or abandoning their vision. The Union Pacific with its 10,000 Irish laborers sped by rapid miles across the plain and crawled painfully foot by foot over canyons and

*Presidential Address delivered at the Centennial Banquet of the Ephraim McDowell Memorial Meeting, the Centennial of the Kentucky State Medical Association, Louisville, October 2-5, 1951.

beneath mountains in a race against time with the Central Pacific whose 12,000 Chinese coolies traversed the arid deserts of California and the impenetrable western Rockies.

There came a day, on May 10, 1869, when the rails from the East met those of the West at Promontory Point, Utah. The entire nation awaited the historic moment. The telegraph ticked off the minute by minute progress to assembled crowds in holiday celebration at New York, San Francisco, Chicago, New Orleans, and cities the country over. The Union Pacific's locomotive, "Old 119," faced the Central's "Jupiter," puffing smoke and hissing steam. Governor Leland Stanford of California faced Dr. Thomas C. Durant of New York across the rails. Each wielded a silver hammer. Montana, Idaho, California, and Nevada provided each a spike, two of silver and two of gold, which driven into a tie of polished California laurel completed a dream of progress and united the East with the West.

Transportation since that day has moved forward at an ever increasing speed. The original road at its point of union has long since been abandoned and there remains now only a trackless grade over which our first transcontinental trains so proudly sped. Eight other transcontinental lines carry passengers and express with greater comfort and speed and in volume multiplied a thousand times. Airlines have dwarfed the proud schedules of the railways and our 150 million people traverse the continent as they would commute to work. A simple pyramid still stands at Promontory Point describing for those who care the historic accomplishment of that far off day. The achievement of those indomitable men who contributed so significantly to our national progress shall forever be monumental in our annals. The Golden Spike remains a symbol in American history.

One might believe that a century of growth with industrial expansion and education would lead to a simpler, more direct and economical solution of our problems than our ancestors were able to find. Progress remains slow and tedious, however, to our present day. Conflicting ideals and objectives, divergent personalities and opinions must be harmonized and brought into a forward direction. Time and wasteful expenditure is required in

such a process. But this is the American Way—the best and most progressive on earth.

When the history of the past two decades is written there will perhaps be brought into clear relief a tremendous surge toward socialization—a trend of the times contrary to our American tradition. Standing directly athwart the path of this moving tide and threatened with engulfment has been the medical profession. Differing in our own opinions, and apparently too small a minority to successfully resist the powerful political pressures brought against us, our position for a long time seemed hopeless. There were those alert and courageous statesmen of medicine, however, who sounded a loud and persistent alarm and began to unify our opposition to this doctrine. At the eleventh hour did we fully realize our peril and resist as a strong, belligerent body of Americans. Help came from those about us who gradually learned that our danger was also their own. Thus, we have been able to turn back the first wave of assault by those who would change and destroy our traditional American Life. It seems now very probable that this heroic stand made by our profession and its friends has not only won the admiration of Americans everywhere but may well mark a turning point in the trend of events away from the socialized state and back toward individual enterprise for our entire economy.

And let us pause here long enough to pay tribute to two Kentucky physician-statesmen. Most Kentuckians feel that during the last twenty years of his brilliant and fruitful life, Dr. Irvin Abell exerted a more beneficial and sustained influence for good on American medicine than any other single person—and this opinion has been frequently expressed by physicians in distant states. Those of us who had the privilege of knowing him intimately as a neighbor and friend will always hold him in the highest and most affectionate esteem for his constructive contributions. When, two years ago, he laid down his work the torch which he had carried with such distinction for so long was passed to the hands of another Kentuckian. At great personal sacrifice during the past five years he has spared neither his health and comfort, nor time nor financial means. In every state in the union and lands abroad he has waged a ceaseless campaign. He has cried from

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the housetops to awaken our profession. Personal friendships in high places have been sacrificed and he has borne without complaint storms of individual criticism and censure. No physician has been more loyal to his ideals and to his profession nor served it better than has the recent President of the American Medical Association, Dr. E. L. Henderson, and to no one man is more due the reward of achievement.

We have stood upon the principle that the practice of our profession unhampered by government regimentation is a sacred American right. We have shown that achievement of the highest standard of health on earth for our people has been and will continue to be best accomplished by the survival of our system of individual initiative. We affirm that the education of doctors is the concern of the people and of the respective states and not an agency of the Federal Government. We have driven a golden spike to connect the historic past with a future of brilliant promise. It may be that we stand today where our road turns away from the social state to safer country. It is our profession's finest hour.

The medical profession is the one agency in the most favorable position to know the problems of health affecting the people and must outline and blueprint the best plans to follow. Individuals, states, and countries spend their money for the things they most want. It is our responsibility to understand and propose honestly and clearly to our citizens and legislators what things in health should and can be afforded for the greatest welfare and with the best economy.

My predecessors in this office have, in recent years, with the guidance and help of our Commissioner of Health and the Council sought to understand clearly the problems affecting the health of our people and to find practical solutions for them. Kentucky is not a pauper state but it is poor in respect to taxable properties and per capita income with a position of 44th among our 48 states. Money must therefore be spent wisely and our health programs built on modest and efficient patterns. Profligate and ill-advised spending on one project will deprive of development others equally essential.

The Kentucky State Medical Association has now three broad objectives, the accomplishment of which seem most urgent and immediately necessary for the

welfare of our people. The first is the improvement and expansion of its Public Health activities; the second, better care of our indigent sick; and the third, expansion of medical education. The first two of these have long held priority in the plans of our Health Commissioner who is, with the help of the Council, initiating practical outlines for their solution. I shall discuss them very briefly. With the third I have principally concerned myself during the past two years and shall discuss it in somewhat greater detail.

Economic pressures of the past decade, scarcity of available trained personnel and salary limitations have put our traditionally fine Public Health Program under the severest strain. Existing County units have required the strictest economy and cutbacks in operation until they are now in real jeopardy. The opening of new full time units in counties most needful and desirous of them has become well nigh impossible. The Governor, in his sympathetic attitude toward health and a full appreciation of the need, has been most cooperative and this year has appropriated emergency funds to this purpose. A wider and more secure base is being sought and will be obtained and this essential feature in medical care will receive the attention it so urgently needs.

There are many counties whose taxation base is so inadequate and whose indigent population is so large that they cannot provide for the care of their sick. These counties require aid from the state at large. Funds from the state must be found to supplement the barest necessary care in those areas. Doctors, where at all available, have always and will continue to provide their services to these indigent sick but they cannot give hospitalization, even where most urgently needed, nor medication, nursing care and the basic essentials of health. We feel it our responsibility as physicians to present to the fiscal courts concerned and to our legislature the practical means by which this pressing need can and will be met.

Kentucky is in need of more physicians. In the United States as a whole there is one physician to 740 people—in Kentucky there is one to 1100, and these are poorly distributed. There are 7 counties with an average population of 7,000 with 1 physician each, and 12 counties with a total population of 96,000 served by only 17 physicians, one doctor per 6,000 people.

The Kansas plan for better distribution of doctors, under the leadership of Dean Murphy, has received wide publicity and acclaim. Similar methods have been practiced in Kentucky since the end of the recent war and with encouraging results. Distribution of the new general hospitals under the Hill-Burton Plan, the building of health units and small clinics now under consideration and the establishment of rural scholarships have already affected this situation very favorably. Continuation and extension of these measures will accomplish a more and more equitable distribution of our physicians to the rural portions of the state.

One reason why we do not have a sufficient number of doctors is that we do not have the facilities for educating them. The University of Louisville School of Medicine, as is true in practically every one of the 72 medical schools in the country, is enrolling every student for whom it can possibly provide facilities of study—a total of 100 in the present freshman class. The freshman class of medical students in the United States for 1950, totalled 7187. Kentucky has 2% of the national population and our proportion of freshman medical students, therefore, should be 140 instead of 100 and we should have graduated 120 instead of 90 of the 6000 medical graduates of last year.

There are adequate numbers of men in Kentucky qualified for and desirous of studying medicine but we do not have the facilities for their education. In 1949, the latest year for which complete statistics were available, there were 4.8 freshman students per 100,000 population for the country at large—of Kentuckians there were 4.6 freshman medical students per 100,000 population but a large percentage of these students sought and found opportunities to enter medical schools outside of Kentucky because we could not accept them. Of these men studying medicine outside the state many do not return to practice. It would appear that if we are ever to have an adequate supply of doctors for practice within the state we must provide facilities for their education.

The American Medical Association through its Council (on Medical Education) has offered plans since 1910, which have revolutionized medical education in the United States. With reduction in the number of schools and elevation of entrance requirements combined with the

effects of the first World War there were only 2304 physicians graduated in 1922, which was the low year for the first half of this century. That depression was only temporary, however, and by 1930, the national output was 4565, in 1940 it was 5097, and in 1950 it was 5553. During the past 20 years, since 1930, while our national population has increased by 14% our yearly number of medical graduates has increased by 21%. In the decade from 1950-60 it is planned to increase by 30% our national annual output of physicians. That is a highly desirable and necessary goal, but it cannot be accomplished unless the existing 72 schools run to full capacity and wherever possible expand their present facilities. Also some new schools are being planned and will undoubtedly be placed in operation during this decade.

With a view toward finding the best solution to this problem for Kentucky the Dean of the Medical School, the Commissioner of Health, and I undertook, early in the year, to gather data and competent advice on our local situation. The secretary and associate secretary of the Council on Medical Education of the American Medical Association spent April 17-18 here and in Lexington making a careful survey of the clinical facilities in each city and from their experience with the same problem elsewhere gave us a complete and most encouraging report. They advised the establishment of a new four year school at Lexington as the most adequate and permanent solution and they furnished very encouraging figures to indicate that the cost of this plan is within reach of our state's finances. An alternate plan recommended was expansion of facilities at the University of Louisville School of Medicine so that we may enter 140 freshmen each year instead of 100 and graduate 125 per year instead of the present 90. This increase would meet our needs at least during the next ten years.

With this data and recommendations in hand and with the associate secretary of the Council on Medical Education in attendance we had a meeting of the Council of the Kentucky State Medical Association on May 30, and again on August 29, devoting the entire days to a consideration of this problem. It was felt by almost every member of the Council that the alternate plan, that is, the expansion of the school at Louisville is the most practical solution for the present because of two principal reasons: this can be accom-

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plished in a much shorter period of time and an increased number of physicians be put into practice when we are urgently in need of them; with our limited resources it is more practical to maintain one exceptionally strong school within the state than to try to maintain two, under constant financial handicap. Our position in this matter is further strengthened by assurance by those most conversant with the state's finances that now, during the Korean Crisis, money is not and will not be available for the state to launch a new medical school even on the moderate basis of cost outlined by recent studies. There is no thought in any instance of lowering our standards or the quality of medical education furnished but rather to strengthen it. The 72 medical schools now in operation in the United States are all A grade. Since 3 years ago when the last of B grade medical schools were either closed or brought to A grade

there are not and should never again be schools of substandard rating.

We as a Council on behalf of the State Medical Association will continue to endorse and press in every way possible for this as the most practical present solution of our problem. Should further study establish that a new and separate medical school at Lexington is feasible and practical and that Kentucky will be able to support both institutions adequately we will gladly accede to the change. But the need for expansion is plain and urgent. Our responsibility as a state is clear. Now would appear to be the appropriate time for decisive action. On the long road of medical progress which has sometimes been slow and tedious and sometimes has moved with speed and brilliance let us drive here yet another golden spike which will declare forever to our citizens and to our posterity that we have served them well.

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The unique marriage in the JMT&K has been so successful that the carrier has expanded into five other states—Indiana, Kentucky, Maryland, Missouri and West Virginia. Where PIE goes there goes JMT&K, with nine branch offices to date. The firm has trial attorneys, and may well be the nation's largest devotee of well-just exclusively to medical malpractice defense.

Could the insurer-defender symbiosis, if duplicated by other doctor companies, make a significant contribution to reducing malpractice litigation nationwide? An up-close look at

"But firm's lawyers read more medical books than law books," says PFE Vice President Gerard C. Oppenheimer, himself a veteran defense attorney. Robert Maynard explains: "New cases are discussed at our weekly staff meeting, so that every lawyer is familiar with every case. But we assign cases to our attorneys according to medical specialty. They're well-versed in the fields, so they don't have to re-vent the wheel with each case."

Last year, the firm's OBG specialist, attorney Jerome S. Kalur, who had won 10 consecutive brain-damaged baby cases, faced one of his toughest challenges when he defended a GE

"I wanted to depose the doctor who'd been involved in the mother's care during her hospitalization, but the attorney for the plaintiff baby insisted it would violate the mother's physician-patient confidentiality. That privilege would terminate automatically when her medical

records were introduced at the tail end of the plaintiff's case. Meanwhile, I was in the no-win position of having to tell the jury "It couldn't have been the midforceps," without offering them another reasonable brain damage theory."

Fortunately, the plaintiffs rested their case on a Fetal Act version, giving JMT&K time for a weekend rally. "Twenty minutes" later," says Kaloupek, "I was in the hospital pathologist's office with an order permitting me to view the mother's placental slides. Mercurum's claim had been chortled, and Kaloupek had a hunch that fetal distress had begun long before the first had begun lung before the first

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Focus on

The number of women physicians and medical students has nearly quadrupled over the past 20 years and AMA projects that in the year 2010, almost 30% of all US physicians will be female. Yet, women's representation in organized medicine has not kept pace with their increases in total physician population.

September has been designated by the American Medical Association as Women in Medi-

Women in Medicine

Ardis Dee Hoven, MD

The concepts and functions of organized medicine were completely foreign to me when I entered private practice of Infectious Diseases in Lexington. Upon entering the medical community, membership in both the Fayette County Medical Society and KMA were provided to me by the Lexington Clinic, and thus began my early association with organized medicine. During those initial years, I was very fortunate to be associated with men and women who would assume leadership roles in the organization, both locally and at a state level. As a Delegate to KMA, I then began to appreciate the activities of the Reference Committees, the House of Delegates, and to observe the leadership of KMA.

Clearly, a strong local society encourages young physician members and lends support to their efforts, both in the private community and in the learning process required to deal with the problems facing the entire healthcare community today.

In retrospect, the element that decidedly propelled me into a more active role in KMA was the AIDS epidemic. As an infectious disease consultant, my educational background and knowledge on the subject enabled me to assist in establishing policy for the KMA and physicians throughout the state. Frequently, a single issue or problem relative to patients and healthcare

may be the impetus for physicians to "get involved" and take an active role in the activities of the local county society or KMA. Unfortunately, many see the activities of organized medicine as unrelated and not applicable to their practice, their community, or even their patients. However, those of us who have been involved recognize that the physician with his or her educational background and specific expertise in a medical field and armed with a great deal of knowledge about patients' needs, can and will impact on the outcome of healthcare policies and the ultimate quality of healthcare.

Today's women in medicine, a large percentage of whom are in primary care specialties, have a unique opportunity to influence healthcare issues, both locally and nationally, in this era of healthcare reform. We have great talent in this state, and I encourage all physicians to be active participants in a process that continually molds the outcome.

As an individual, I have recognized and appreciated the step-by-step process necessary to achieve CHANGE by a democratic process manifested in the activities of the KMA and most recently as an Alternate Delegate to the AMA. Clearly, to see a large group of physicians working together to achieve improvement in policy and ultimately seeing how this affects the



outcome of both state and national legislative efforts is exciting and gratifying.

I enjoy being on "the cutting edge" of medicine, both in my medical specialty and in my activities at KMA and AMA. Women in medicine today have new opportunities and responsibilities to fulfill. I encourage all physicians to avail themselves of this work. It is worth the invested time, energy, and resourcefulness because the outcome will be improved healthcare for our patients, improved accessibility to healthcare, and an improved environment in which to practice medicine.

Dr Hoven is 1991-92 KMA Vice President and Alternate Delegate to the AMA. She has been nominated as President-Elect of KMA for 1992-93.

Women in Medicine

cine Month to bring attention to the growth and achievements of women physicians/medical students and to increase membership in organized medicine among this important group. The KMA Membership Committee joins in this salute and is pleased to highlight a few of the many women physicians in Kentucky who contribute so significantly to the advancement of health care policy. — Harold D. Haller, MD, Chairman, KMA Membership Committee

Why I Became Involved in Organized Medicine

Beverly M. Gaines, MD

I cannot recall a specific day or event that triggered a conscious decision on my part to get involved in organized medicine. Through the years I have come to appreciate the fact that in order to make a difference you must first **get** involved. I hope that in this journey through my medical career I am able to make a difference, for those who travel this way with me and for those who travel this way after me. I feel, then, by entering the arena of organized medicine I am making a substantive contribution to both my profession and my community.

I made an observation early in my medical education, and unfortunately it is still holding true today, that there is a great disparity between the diversity of the patients and the physicians delivering care to the patients. Closing this diversity gap is an important issue for me. In medicine, it is imperative that our membership and leadership be diverse, so when the collective voice of organized medicine speaks, it is speaking for all of those it is intended to represent and serve. Whether our associations are able to do this or not is dependent upon active participation from as many different members as possible.

As a member of the Kentucky

Medical Association, I feel it is my responsibility to participate and share my thoughts and feelings with my colleagues in the Association. I support the belief that we are the sum total of our previous experiences, therefore our perspectives on the same issue can be totally different because we are using different data bases. I strongly encourage all members to actively participate and nonmembers to join and be heard, so that when the Association speaks, it speaks for all of us.

I can remember a time in medicine when the female physician was a relative newcomer, and now it is projected that we will make up a major part of the primary care force by the year 2000. I can also remember a time when the number of African American physicians was on the rise; today the number of African Americans entering the medical profession is on the decline. These are just a few of the many reasons I feel that I, an African American, female physician, need to be actively involved in organized medicine.

As an African American, a female, a mother, a pediatrician, a business owner and operator, and a community volunteer, I feel I have a great number of responsibilities. I am sure this is a feeling shared by many



female physicians. However, participation in organized medicine is a commitment beyond direct patient care that allows us to help people and give back to our community. Yes, involvement can require balancing and prioritizing in our lives, but as citizens of the medical community and the community at large it is a commitment we need to make.

Dr Gaines is Secretary of the Jefferson County Medical Society Board of Directors and JCMS Foundation. She currently serves on the Governor's Task Force on Health Care Access and Affordability.

Making A Difference

Baretta Casey, MD

I became a physician because of a driving force inside of me placed there through my life experiences. These experiences created compassion for the suffering and a desire to understand the causes, effects, and treatment for the sick and diseased. Family and humanity taught me compassion. Medical school taught me anatomy, physiology, pathology, and interpersonal skills. Along the way, I have realized I will and must always be a student as well as an advocate of my profession and my patients.

The way I can contribute to the development of health care policy is to participate in organized medicine. I became involved in the Kentucky Medical Association and the American Medical Association as a medical student when I learned there was a Medical Student Section (MSS) at the state and national levels which provided for a voting delegate from each medical school in the United States. My first national meeting was in December 1986 in Las Vegas at the AMA-MSS Interim Meeting. I returned from this meeting convinced that even medical students have a voice and can make a difference in how we practice medicine in the future. Medical students hold office in local school chapters of the MSS and both students and residents serve on KMA committees and in leadership roles at the national level. Resident and student involvement has been instrumental in policy-making at the AMA and KMA and has even brought about legislative changes in our state.

As a second-year resident at the Trover Clinic Foundation Family Practice Residency Program in Madisonville, my commitment to my

career goal of being a good physician has continued. The residency program has encouraged my continued involvement in organized medicine and I am currently active in the KMA Resident Physicians Section as well as KAFP and AAFP.

It's interesting to note that the AMA was originally formed as a result of a resolution proposed by the New York State Medical Society stating that "a national convention would be conducive to the elevation of the standard of medical education in the United States." The AMA and KMA have remained committed to medical education of students and residents, as well as continuing medical education of practicing physicians. Formed in 1847, the AMA is still the largest body of physicians working together for the betterment of the practice of medicine and the care of patients.

To practice medicine today, we evaluate, diagnose, and treat patients to the best of our knowledge and skills. To do this, we must also deal with private insurance companies, Medicare, Medicaid, and state and federal laws. Now we are facing health care reform both in our state and at the national level. If we, as physicians, are to be the advocates of our profession and our patients, then we must each be a part of the policy-making process.

Whether you're a medical student, resident, or practicing physician, you can make a difference in how you practice medicine — but *only* if you become involved with your colleagues in organized medicine.

As a female physician, I am one of 30% of all US physicians. I am a



wife and a mother. All of my roles are important to me. As the number of women physicians increases, we must also assure we are represented in the leadership roles of organized medicine. Women have innovative, productive ideas which have proven to be of great value in medicine. For the AMA and KMA to continue to represent *all* physicians, all women physicians must become active and let their voices be heard.

Dr Casey is the President-Elect of the KMA Resident Physicians Section and chairs the Subcommittee on Domestic Violence, a part of the KMA Community and Rural Health Committee.

Renaissance for Women in Medicine

Mary Ann Barnes, MD

No one should have to dance backward all their life.

— Jill Rucklehaus, officer
US Commission on Civil Rights

Women are finally breaking into the ranks held traditionally for men only: Antonia Novello has been appointed surgeon general of the United States and Bernadine Healy, the director of the National Institute of Health. Women had been repressed in past centuries by traditional medical education, left to do only the most humble and inelegant jobs. This century has seen a renaissance for women. The changes we have made have been accomplished slowly, through the efforts of many women and men. However, we are far from achieving parity.

Early in my experiences in private practice I saw need for some big changes in this world, and decided to look for the power to make them! I considered law school and then politics, but then came to the revelation that change in society is possible only through education of the community.

But, how do you get another person to change? You can't. The only person you can change is yourself! You can provide information about problems and need for change, providing each individual with their own opportunity for making a difference. I have finally discovered that the barriers to change lie within each of us. We are our own biggest obstacle for change.

Through this growth process, I

have met and benefitted from knowing a lot of people, and have been presented with opportunities to be educated, to educate, and to make a difference. Key persons who have given me an opportunity to participate in organized medicine and leadership roles in the community include: my dad, who fostered the self-confidence from an early age that I didn't have to fit any one mold; Forrest Calico, who provided immense support, encouragement, and opportunity for professional growth, both in medicine and the community; Don Swikert, who knew me well enough to know the right buttons to push to interest me in organized medicine; and Bill Monnig, who has worked hard to ensure equal representation of women in medicine. These advocates have removed many hurdles and smoothed my way, making it possible for me to provide input into our community.

But through my personal experiences, it has become clear that despite the great strides made in providing women equal opportunity in medicine, old paradigms still dominate our behavior and create barriers to parity. There appear to be members of both sexes still operating, thinking, and living under these paradigms.

Old Paradigm: Women don't make good managers. An atmosphere of mutual respect is needed for men and women to be treated fairly. There are a handful of men who hear me without listening; I never feel they are present in conversation with me. A lack of respect is manifested in a



number of ways in medicine. The medical education culture and health care management systems are still patriarchal. Women are underrepresented in medical schools as chairs of departments and deans. Even the chances of achieving full professorship are half that of men. As in the business world, a "glass ceiling" appears to exist in hospitals and insurance industries; women are not promoted above mid-level management. Some medical specialties train few women suggesting bias in education or selection processes, eg, urology, cardiology, and surgery.

New Paradigm: As we learn about "win-win" solutions and negotiated joint outcomes, the value of feminine qualities are being recognized for creating much more enduring success than the old "win-lose" competitive model. Women and men must work to resolve these inequities in medicine and business. Because many of the decisions for promotions and board positions are made by networking, and most networking is informal, every effort should be made to look for qualified women candidates as positions open.

Old Paradigm: Women aren't committed to their work. This is based

on the notion of medicine as the "queen" of the physician's soul, superceding all other aspects of life. Women in medicine don't fit this stereotype because they often delay childbearing and must juggle parenting with the practice of their profession. Women, on average, work fewer hours and see fewer patients (they also spend more time with each patient!). Interestingly, though 17% of practicing physicians in Kentucky are women, only 6% of disciplinary actions taken by the Kentucky Board of Medical Licensure in the past 2 years were taken on women. Women in employee positions are paid less than their male counterparts who have equivalent experience.

New Paradigm: As young physicians penetrate the health care system and medical communities, focus is shifting from total self-sacrifice to balance between self-fulfillment, family, and service to patients and community, not only in women, but also in men. Achieving this balance will allow

physicians to be complete persons, attending to their own body, mind, and spirit.

Old Paradigm: Sexual Harassment is not a big problem in medicine. I didn't really believe sexual harassment was that big a deal *until* I was in medical school, where I saw it and experienced it. It is more pervasive in specialties with the smallest representation of women. An AMA survey in 1988 found that 81% of the women in a third-year medical school class had been victimized by sexual slurs. The effects of this experience and the tolerance of it by the medical education system serve to continue the male-dominant attitude, and undermine women psychologically and professionally.

New Paradigm: Sexual harassment, not always subtle, is real at all levels of medical education and practice, as it is in our entire society. Hence, it must be dealt with openly and purposefully by both men and women.

Representation of women in leadership in medicine is crucial for women to feel an integral part of our medical community and to enable medicine to achieve its ideal mission in society. Both men and women in medicine need to facilitate this development and break down the barriers that thwart growth. Each person must learn and grow in the direction of breaking down the old and adopting the new paradigms.

If women are to have presence in leadership roles that is proportionate to their numbers and is essential for medicine to meet today's challenges, both men and women at all levels of membership must facilitate their integration into the medical community and its leadership.

Dr Barnes is President-Elect of the Northern Kentucky Medical Society, encompassing Boone, Campbell, and Kenton counties.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

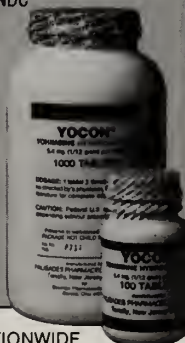
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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The Truth or Consequences

"As physicians we are under constant scrutiny at work, at leisure, and at home. We must not only stand for compassion but integrity as well."

I recently viewed a segment on "Prime Time" which dealt with rating hospitals and surgeons according to the number of procedures they do, the difficulty of the cases, and the mortality and morbidity rates. During one portion of the show, a reporter posed as a patient and spoke with the surgeon. This ratings list was mentioned and the doctor was asked as to where he stood on this list. In the instance aired, the surgeon gave false information as to his ranking on the list and the number of that type of procedure he does. When this was exposed, the facial expression and the body motions from the physician told the story in and of themselves. He was caught in a trap.

My initial feelings toward this television segment were entirely predictable. I felt that this was just another case of doctor bashing. I also felt that the reporter had been deceitful. He went under cover and posed as a patient which in my mind seemed like a set-up.

Just as my anger was escalating, my insightful wife cut through to the heart of it all. She commented on how uneasy that physician looked and that this could have been avoided if he had just told the truth. Then it all became clear, this segment was not about who was being mistreated or who was being deceitful. It was about truth and integrity.

I don't agree with the way the data was collected and in fact it probably would not have been aired had the truth been told. Hidden in all this however is a message. As physicians we are under constant scrutiny at work, at leisure, and at home. We must not only stand for compassion but integrity as well. We can't let pride cause us to compromise our values and entangle us in a web of deceit. Even though these TV segments seem offensive and degrading, let us see the message underneath and learn from it.

William P. Hoagland, MD

SEPTEMBER

25-26 — 5th Annual Rehabilitation Management for the Primary Care Physician; Radisson Plaza Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

25-26 — 6th Annual Multispecialty Oculoplastic Surgery Symposium — A conjoint symposium by specialties involved with the management of problems of the midface and ocular adnexa; Marriott's Griffin Gate Resort, Lexington, KY. Contact: Julie Burlew, RN, The Center for Advanced Eye Surgery, Humana Hospital-Lexington; 606/268-3769.

OCTOBER

2-4 — Pediatric Heart Disease: Echocardiographic Evaluation from the Fetus to the Adult; Hyatt Regency Hotel, Lexington KY. Contact Continuing Medical Education, K-112 Kentucky Clinic, University of Kentucky, Lexington KY 40536-0284; 1-800-888-5533, ask for CME or 606/233-5161.

24 — Hyperlipidemia: Treatment and Diagnosis; Marriott's Griffin Gate Resort, Lexington, KY. Contact Continuing Medical Education, K-112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1-800-888-5533, ask for CME, or 606/233-5161.

25-30 — 23rd Family Medicine Review, Session III; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

29-31 — 42nd Annual Obesity & Associated Conditions Symposium, sponsored by the American Society of Bariatric Physicians, The Westin Hotel, Chicago. Contact: ASBP, 5600 S Quebec St, Ste 160-D, Englewood, CO 80111; 303/779-4833, FAX 303/779-4834.

30-31 — 26th Annual Newborn Symposium, The Seelbach, 500 Fourth Ave, Louisville, KY. Contact: Lynette McInnis, University of Louisville, Department of Pediatrics; 502/588-5329.

NOVEMBER

8-12 — 96th Annual Meeting of The American Academy of Ophthalmology; Dallas Convention Center. Contact: The American Academy of Ophthalmology, Meetings Dept, PO Box 7424, San Francisco, CA 94120-7424; 415/561-8500.

12-15 — Southern Medical Association's 86th Annual Scientific Assembly; San Antonio, TX. Contact: SMA's Member Services Center; 800/423-4992; or 205/945-1840.

27-December 4 — 78th Scientific Assembly and Annual Meeting of the Radiological Society of North America (RSNA), McCormick Place, Chicago. Contact: RSNA, 2021 Spring Road, Ste 600, Oak Brook, IL 60521, 708/571-2670; FAX 708/571-7837.

FEBRUARY

7-11 — Southeastern Surgical Congress Annual Meeting; Tarpon Springs, FL. Contact: Southeastern Surgical Congress, 1776 Peachtree St, NW, Suite 4010N, Atlanta, GA 30309; 404/607-8958.

Wellness Forum Meeting to Feature C. Everett Koop

Doctor C. Everett Koop, the former surgeon general of the United States, will be the keynote speaker at the Wellness Forum in September.

Koop will discuss "The State of Health Care in America" at the forum's September 30 Annual Meeting, Galt House, Louisville.

For reservations, contact Scott Bartelt at 896-1058.

Help for Impaired Physicians

Through its Committee on Impaired Physicians, KMA helps doctors who are suffering from alcoholism and drug addiction. The thrust of the program is rehabilitative, not punitive. The Committee is composed of physicians who have special expertise in these areas, some from personal experience. Effective treatment for these illnesses is achieved most easily when the disease is detected early; family, friends, and associates are urged to avoid misguided sympathy which enables the condition to deteriorate.

HELP US TO HELP

Call the KMA Impaired Physicians Program
(502)426-6200.



“Even if you can’t be actively involved, your dues will mean those who can will continue to make a difference on the issues that concern all of us.”

Auxilians Making a Difference

The Auxiliary to the Kentucky Medical Association is a diverse group of members who share a common bond — we are all married to physicians. Our professions include homemaking, engineering, nursing, medicine, teaching, counseling, retail marketing, accounting, the law and politics just to name a few. In our spare time we do needlepoint; we fly; we paint; we quilt; we work in political campaigns; we sponsor cheerleading squads; we sit on school boards; we volunteer in churches, schools, hospitals all over the Commonwealth; we are big brothers and big sisters; and we build houses through agencies like Habitat for Humanity. We also work as advocates for medicine to show that Kentucky physicians and their spouses really care about the health of Americans.

The thread that joins us all together is our marriage to a physician. There is strength in our diversity because through it we touch the lives of many different Kentuckians. It is the goal of the Auxiliary to promote quality health care by serving as advocates for medicine. With the constant changes in the health system, it is increasingly important for those affected, and

those who care, to stay informed.

If you are as concerned as we are that many Americans have no access to health care; that there’s a crisis in adolescent health; that laws and government regulations hinder how physicians practice medicine; that funding cuts mean some bright young people won’t be able to pursue a career in medicine — if you care about these issues, please join this nationwide network of spouses who care. Even if you can’t be actively involved, your dues will mean those who can will continue to make a difference on the issues that concern all of us.

If you live in a county that has an organized medical auxiliary, I encourage you to contact them and join as a federated member. If you live in a county that does not have an organized medical auxiliary, I urge you to join us as a member at large. You can do that by sending a check for \$40.00 to the address below. Please join us as together we work today for a better tomorrow.

Beryl Dadds

AKMA President

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RATES AND DATA

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Deadline: First day of month prior to month of publication.

Word count: Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

Rates to KMA members: \$10 per insertion up to 50 words, 25¢ each additional word. To non-members; \$30 per insertion up to 50 words, 25¢ each additional word.

Send advance payment with order to: The Journal of KMA, 301 N Hurstbourne Pky, Ste 200, Louisville, KY 40222.

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PEOPLE

KMA member **Paranita S. Bratton, MD**, was among the 50 class members selected for the 1992-93 Leadership Louisville Class. Members meet monthly from August until May to familiarize themselves with the opportunities, needs, problems, and resources in the community on a variety of issues.

Salvatore J. Bertolone, MD, was one of 11 people to receive the prestigious Jefferson Award, a Nobel-like recognition for public service established in 1972 by Jackie Onassis and former US Senator Robert Taft, Jr of Ohio.

Dr Bertolone is a pediatric hematologist-oncologist at the U of L School of Medicine and Kosair Children's Hospital. He established one of the first pediatric hospices in the country and worked to set up the local Ronald McDonald House and Louisville's chapter of the Dream Factory.

Award winners get no money but receive a bronze medallion. Dr Bertolone won under the "unsung-hero" category.

Earlier this year, the *Congressional Record* included a tribute by Senator Mitch McConnell to **Donald C. Barton, MD**, Corbin. Senator McConnell recognized Dr Barton for being named by the Kentucky Academy of Family Physicians as the 1991 Citizen Doctor of the Year. The award is one of the academy's highest and is given to physicians by their peers. "He was head and shoulders above the rest," according to **Dr Rick Miles**, Russell Springs, chairman of the nominating committee, as he spoke of the many doctors nominated for the award.

Dr Barton has held multiple offices in the KMA and KAFP. His involvement is not limited solely to the medical field, as he has been a

member of numerous civic and community organizations.

Judy Linger, MD, second-year psychiatry resident at the University of Kentucky, was elected as an At-Large Member of the AMA Resident Physicians Section Governing Council at the AMA-RPS Annual Meeting held June 18-21 in Chicago.

Doctor Linger's leadership experience at the AMA and KMA levels has been extensive during her medical school and residency periods. A member of the KMA Medical Student Section Governing Council, she was elected Chairperson of the AMA-MSS Council in 1990. As a resident, she serves as a representative from the University of Kentucky on KMA's RPS Governing Council and is currently Alternate Delegate to the AMA-RPS.

outside services such as portfolio management for investments. The agreement should position Kentucky Medical for even greater future growth and financial achievements.

Kentucky Medical's President and CEO, Steven L. Salman, said that all three organizations are similar and could benefit greatly from this relationship.

Collectively, these companies represent 15,000 physician and hospital policyholders in four states with over \$67 million in annual written premiums, over \$350 million in assets, and nearly 200 employees.

Company officials expect the details of such a business combination to be spelled out in a definitive agreement by the end of the year.

KMA Addresses Domestic/ Interpersonal Violence

Under the direction of **Baretta Casey, MD**, a Subcommittee on Domestic/ Interpersonal Violence met last month to analyze the growing problem of violence in the home, specifically regarding spouse abuse.

The Subcommittee recognized several myths associated with domestic violence:

- The physician may face a lawsuit for reporting domestic violence.
- Reporting domestic violence creates a worse situation for the family.
- Striking a spouse is acceptable.

The Subcommittee recommended that the KMA develop a program to educate physicians on problems of domestic violence, the present reporting laws, and where to report when recognizing abuse.

The Subcommittee will continue to work and develop an educational program to assist physicians in recognizing and reporting domestic violence.

UPDATES

KMIC Agrees to Business Combination

Calling it "good business" and "an innovative concept," Kentucky Medical Insurance Company, Louisville; Physicians Insurance Company of Ohio, Pickerington; and Physicians Insurance Company of Indiana, Indianapolis, have signed a Letter of Intent to enter into a business combination. The proposed plan envisions the formation of a holding company, which would become the parent of the three medical professional liability insurance companies.

According to KMIC, the potential benefits of such a combination include efficiencies in areas such as reinsurance, access to capital markets, and potential cost savings from

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Bell

Kumaralingam Nagalingam, MD —IM
19th & Lothbury, Middlesboro 40965
1984, Madras U, India

Boyd

Michael J. Goodwin, MD —ORS
500 St Christopher, Ashland 42201
1980, Louisiana State U

Daviess

Jeffrey K. Anderson, MD —AN
1635 Copper Creek, Owensboro 42301
1987, U of Iowa

Graves

Brian K. Gaw, MD —PD
220 W Walnut St, Mayfield 42066
1982, U of Rangoon

Hardin

K. John Yun, MD —OTO
906 Woodland Dr, Elizabethtown 42701
1987, U of Minnesota

Jefferson

Shanker Chandiramani, MD —C
1900 Bluegrass Ave, Louisville 40215
1980, SMT, NHL Medical College, India

Michael C. Cronen, DO —An
4001 Kresge Way #122, Louisville 40207
1984, College of Osteopathic Med, Kansas City

William F. Jessee, MD —PM
PO Box 1438, Louisville 40201
1972, U of California

Steven J. McCabe, MD —PS
225 Abraham Flexner #800, Louisville 40202
1980, U of Toronto

Marc C. Newman, MD —FP
1815 Roanoke #1, Louisville 40205
1987, Northeastern Ohio U

McCracken

Gary Bodnarchuk, MD —GE
2525 Broadway, Paducah 42001
1986, S Illinois U
Robert G. Kupper, MD —U
440 Wellingborough Ln, Paducah 42003
1985, U of Kentucky

Nelson

Kevin D. Dew, MD —OBG
510 N Second St, Bardstown 40004
1988, U of Louisville
William L. Hagan, MD —FP
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DEATHS

Jack B. Holt, MD
Russellville
1933-1992

Jack B. Holt, MD, a surgeon, died May 21, 1992. Dr Holt was a 1959 graduate of Vanderbilt University School of Medicine and was a member of KMA.

Joseph Schickel, MD
Seminole, FL
1914-1992

Joseph Schickel, MD, a general practitioner, died May 23, 1992. A 1939 graduate of the University of Louisville School of Medicine, Dr Schickel was a life member of KMA.

Edward G. Houchin, MD
LaGrange, KY
1922-1992

Edward G. Houchin, MD, a family practitioner, died June 14, 1992. Dr Houchin graduated from the University of Louisville School of Medicine in 1946 and was a life member of KMA.

George E. Dodson, MD
Madisonville
1920-1992

George E. Dodson, MD, a retired obstetrician-gynecologist, died June 22, 1992. A 1953 graduate of Temple University School of Medicine, Dr Dodson was a life member of KMA.

Centennial Celebration Jefferson County Medical Society

The Jefferson County Medical Society recently celebrated its 100th anniversary with a gala event at the Galt House in downtown Louisville. Their Annual Meeting with installation of officers was held the same evening.

On behalf of KMA, President S. Randolph Scheen, MD, presented a beautifully framed 1882 University of Louisville Medical School diploma to the Society. Outgoing JCMS President Linda H. Gleis, MD, graciously accepted the presentation.

Other highlights of the evening included the installation of Norton G. Waterman, MD, as JCMS President for 1992-93, and entertainment by The Medical MS-Fits from the JCMS Auxiliary.

KMA



JCMS outgoing President Linda H. Gleis, MD, is pictured with KMA's gift, an 1882 framed U of L Medical School diploma.



Left, President S. Randolph Scheen, MD, presented a gift to the Society from the KMA. Right, JCMS Executive Director Lelan K. Woodmansee stands beside a cake which replicates the original structure that housed the Society. In the background is a pictorial history of the Society which was compiled by a committee chaired by Eugene H. Conner, MD.



The Medical MS-Fits, L to R, Sharon Watkins on piano, Adelyn Spalding on trumpet, Martha Harris, Betty Davis, Barbara Cox, Jan Reiss, Mary Johnson, Norma Twyman, Anne Nichol, and Sue White.

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*The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control. A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food.

†Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

‡Verapamil should be administered cautiously to patients with impaired renal function.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control of heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents.

References: 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil in Focus*. New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbo KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol*. 1990;66:131-151. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol*. 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation*. 1987;75:1030-1036. 6. Midtbo K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology*. 1988;39:1025-1029.

Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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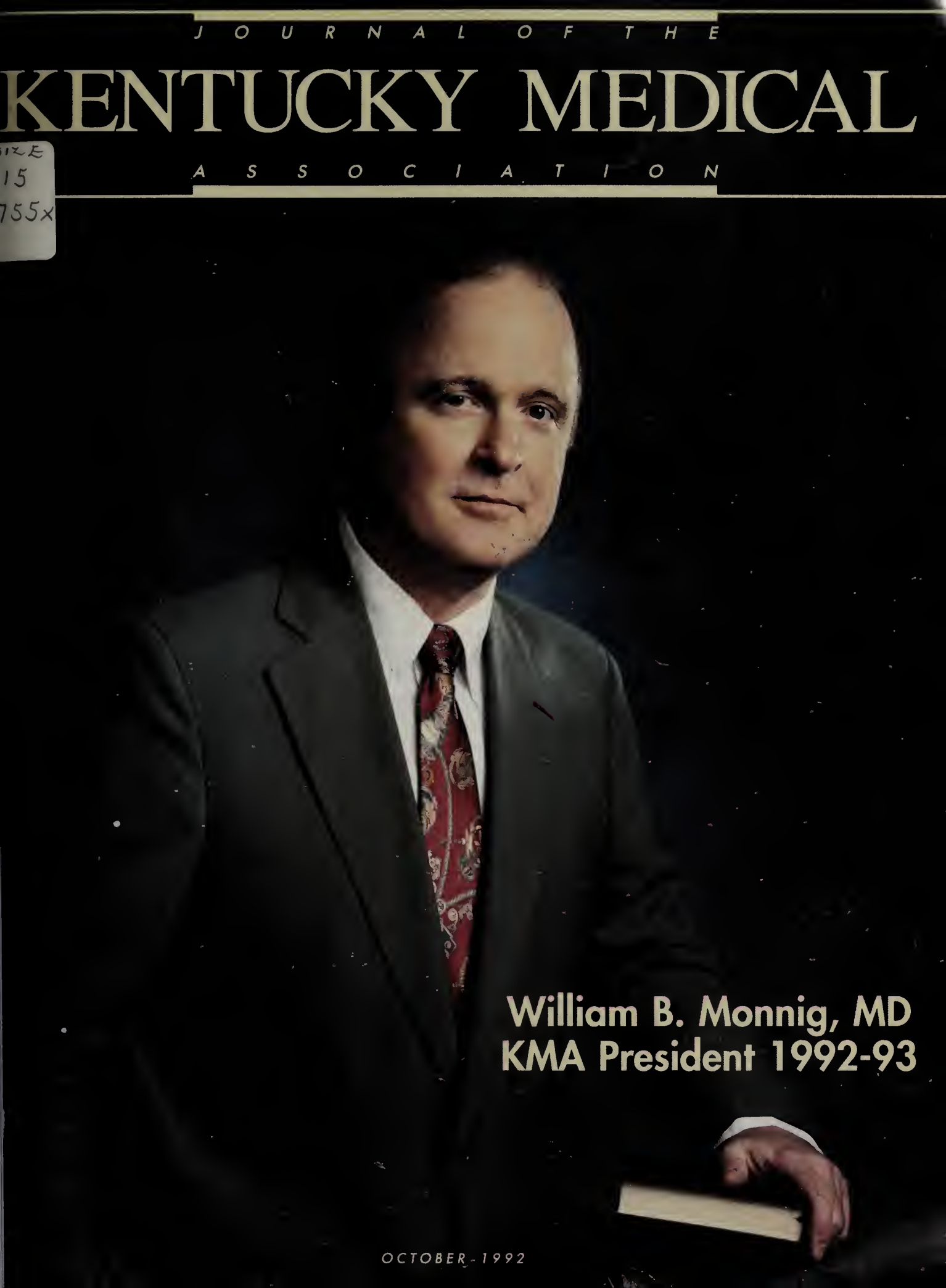
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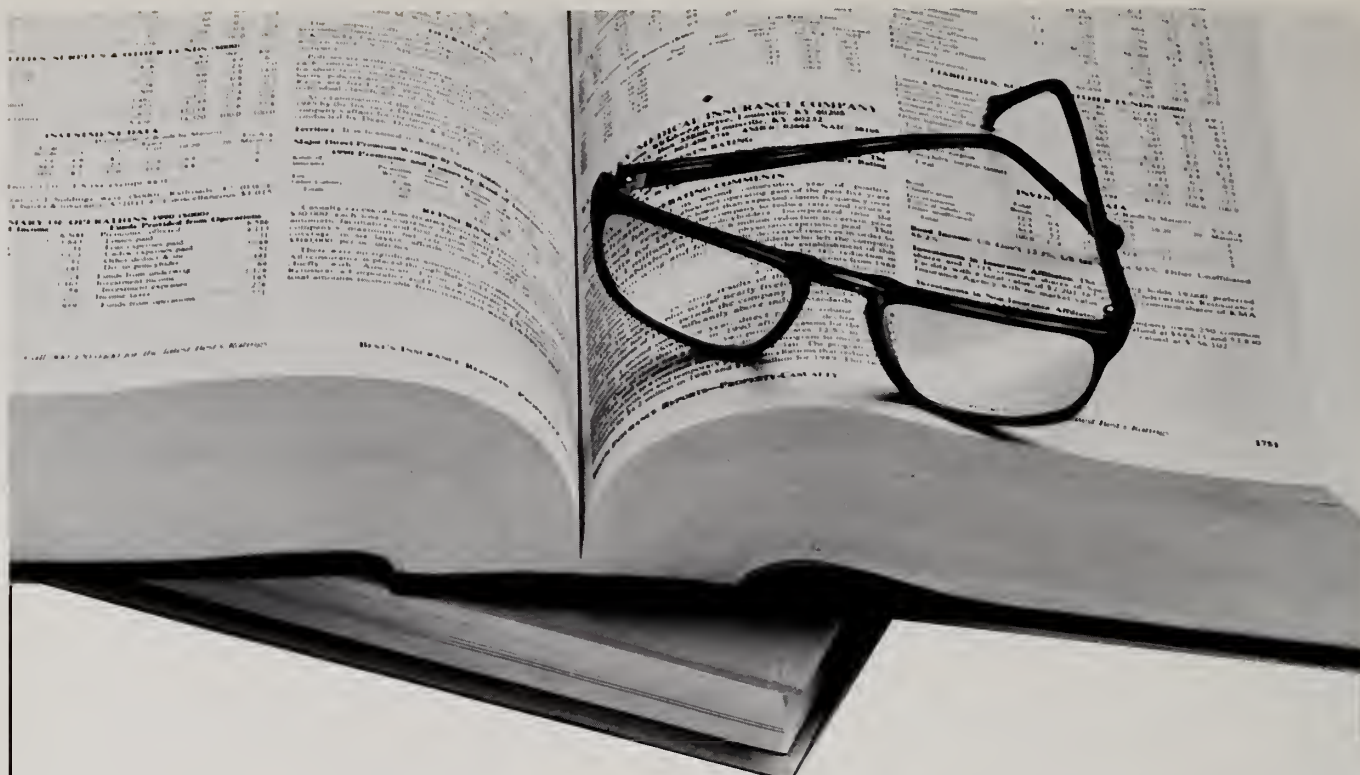
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A black and white portrait of a man, William B. Monnig, MD, wearing a dark suit, white shirt, and a patterned tie. He is looking directly at the camera with a slight smile. His right hand is resting on a book or folder at the bottom right of the frame.

William B. Monnig, MD
KMA President 1992-93

OCTOBER-1992



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COVER: KMA's new President William B. Monnig, MD, presents his inaugural address in this issue—page 497.

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Inaugural Address

William B. Monnig, MD

Thank you very much for allowing me to serve as the 142nd President of the Kentucky Medical Association. I greatly appreciate the honor and want to assure everyone that I will remain dedicated to fulfilling the KMA's mission of service to patients and preservation of the rightful role of physicians as the professional leaders in delivering health services to the patients of this Commonwealth.

On behalf of all the physicians of the KMA, I want to again recognize and thank Dr Randy Scheen, our 141st President, for his leadership and unsurpassed years of service to the Kentucky Medical Association. He has essentially devoted his whole professional life to the dual obligations of the private practice of dermatology and the promulgation of the KMA's professional associational activities.

We are living in a time of rapid change. Health care and its cost is becoming an issue of importance to everyone. Health care is no longer portrayed as a preferred

community service. Over the past 40 years, it became an insurable commodity, then an insurable benefit of employment, and now a societal right for everyone.

In the United States, a period of introspection is developing. The economy is recovering at an unexpectedly slow pace. We see too many people unemployed, too many people who are homeless, too many children who are suffering in poverty,

and too many people who cannot access or afford health care.

At the national level, there is a lack of consensus about how to fix the health care crisis. There have been more than 70 pieces of legislation introduced, but only one has gotten out of its first committee. The inertia of Congress will not be overcome.

At the state level, balanced budgets are constitutionally required and rising health care costs are in danger of destroying the budget. Governor Jones wants health care reform and not only wants it affordable but accessible to all. The stage is set for a political and legislative solution to health care reform.

The affordability and accessibility of health care is this year's highest priority. The KMA is committed to meaningful health care reform. We can be a strong partner to those who want to create a cooperative process for health care reform. We pledge ourselves to actively participate in any good faith effort to revise the health

"The Kentucky Medical Association is well organized and well staffed to be a leading partner in health care. We represent the essential element, the lynch pin, the keystone to quality patient care — the practicing physicians of this state."

Inaugural Address — William B. Monnig, MD

care system so that all patients in the state of Kentucky receive adequate health care at reasonable costs. We will work with the executive and legislative branches of government as well as representatives of the private sector to define a basic health care benefit package that every Kentuckian will be able to obtain. We are willing to use the expertise of our physicians and the leadership of organized medicine to implement the use of practice parameters and outcomes assessment to assure the public that health care quality will not suffer as costs are contained. We will assist the public and private sectors to refine the development of physician practice profiles so that physicians are aware of the financial impact of their practice patterns. Such profiles will not only be used for self-evaluation but will allow purchasers of health care to contract with cost effective physicians. We are willing to work with the Governor and the legislature to create a system of payment for physician services that is fair and equitable. We will foster programs and processes that encourage physicians to enter primary care and encourage location of physician practices in underserved areas of our state. We will work with government's representatives and insurance companies to develop an insurance system that decreases administrative costs. We will continue to advocate health insurance reform that allows everyone to obtain and maintain health insurance at reasonable rates.

The Kentucky Medical Association is eager to explore alternative methods of delivery of basic health services so that everyone can obtain access to preventive and primary medical care.

The Kentucky Medical Association is well organized and well staffed to be a leading partner in health care. We represent the essential element, the lynch pin, the keystone to quality patient care — the practicing physicians of this state. If

"The KMA is committed to meaningful health care reform. We can be a strong partner to those who want to create a cooperative process for health care reform."

meaningful health care reform is to be created and implemented, the practicing physicians must embrace the reforms and work for their implementation. No one should underestimate the power of the practicing physicians to create an atmosphere of teamwork and camaraderie or to create an atmosphere of distrust and self interest. Each individual physician has direct access to the lifeblood of this reform movement — the patient. The patient-physician relationship is a relationship that continues to be held in high esteem despite the public's cynical attitude about the health care system. The KMA will continue to advocate patient issues and strengthen the bond between patients and physicians.

We can be a leading partner in health care reform, and we are willing to assume that role. We refuse to passively accept the dictates of a reform movement that will not acknowledge our essential role to the process. In health care reform, we refuse to be shunted aside as just another special interest group. In health care, physicians are the essence of health care delivery. We provide patient care, we order patient tests, and we prescribe patient medicines. Many peripheral interests have created profitable businesses providing patient services. Their financial stake in health care reform is considerable and their lobbying efforts to preserve their business

interests will be great. But physician interest in health care cannot be equated with those of the health care businesses. We expect to be an integral part of the health care reform process.

The KMA understands that the state health care reform process is both a political and a legislative process. We are not neophytes to the political process. We will use our experience and deep-seated interest in the issue of patient care to educate each elected and government appointed official about the consequences of their decisions regarding health care reform. Each proposed reform will be challenged to determine if it improves patient care, if it helps make patient care more affordable. The legislators and executive branch will be held publicly accountable for their decisions.

We, the elected leaders of the KMA, can assure our members, and the public, that our state legislative committee and our staff are seasoned veterans of the state legislative process. We feel confident that we are prepared for creating a legislative solution to health care reform.

The KMA needs to be an integral part of health care reform. If the executive branch or legislative leadership fails to recognize our essential position as a partner in developing health care reform, we will use our commitment and dedication to patient care issues to overcome those initiatives that did not take into consideration our well thought-out solutions. We will be prepared to use our common bond with patients to generate a grass roots mandate for the appropriate reforms. We have been fortunate in Kentucky to have a cooperative relationship with the governor's office about health care issues. Governor Jones has worked with the Physician's Care Program since its inception. Major state initiated health care reform will test that relationship again and again.

We have also worked effectively and in good faith with many members of the house and senate over the years. All of these elected officials can depend on the KMA's continued good faith efforts.

There are a number of obstacles to meaningful state health care reform in Kentucky. Tort reform is essential to decreasing the influence of defensive medicine on the cost of health care. Tort reform also is essential to improving the quality of health care if we consider performance of excessive tests and prolonging treatment regimens a quality issue. Meaningful tort reform mandates amending Section 54 of the state Constitution. The special session of the legislature cannot create laws

"We pledge ourselves to actively participate in any good faith effort to revise the health care system so that all patients in the state of Kentucky receive adequate health care at reasonable costs."

that require constitutional amendments.

Adoption of a basic health benefits insurance package as the minimum allowable health insurance policy in the state will need federal ERISA law exemptions. Creation of a large pool of insureds to facilitate competitive bidding for the state health insurance plan will require exemptions from the Medicaid laws and regulations. Removing federal mandated services from the Medicaid program to facilitate a uniform benefit plan will require Medicaid waivers.

Suggested financial disincentives to medical schools to encourage increased production of primary care physicians may require Medicare waivers. Different payment schedules to encourage rural practice and practice in underdeveloped areas will require Medicare and Medicaid waivers. Adoption of a competitive bidding process to serve the large state pool may require federal and state anti-trust law exemptions for physicians. Each of these obstacles cannot be adequately addressed by the state legislative process and therefore are not likely to be overcome in time for a July 1, 1993, implementation date. Therefore, our original expectations of a comprehensive revision of health care to be effective July 1, 1993, needs to be tempered by reality. Incremental health care reform seems more likely to be embraced.

The methods of financing health care reform need to be scrutinized. The cost of each reform element needs to undergo a reality test. Can the state afford to assume the financial responsibility for the cost of all of the state's population below 185% of the poverty level, below 150%, or even below 100% of the poverty level? At the same time, can the state maintain a satisfactory level of benefits for the state employees, teachers, retired teachers, and others presently covered by state financing? Even if the state mandates health insurance coverage of all employees by the employer, the state financial responsibility will escalate during poor economic times, as more and more people become unemployed. The state must balance its budget, and extending health benefits to ever-expanding groups of people will make that task more and more difficult. A legislative solution that requires future tax increases, or cuts in salaries, or cuts in services is rarely a popular legislative solution.

Again, there is reason to encourage incremental health care reform. The KMA advocates health care reform that addresses the issue of access but that does not lose sight of what is achievable from a financial standpoint. It does little good to recognize an individual's inability to pay for needed services and address that shortcoming by creating a state assisted system that cannot be adequately funded. Our health care reform needs a financial reality test. The KMA will be ever vigilant of efforts to let no physician be lulled into complacency because health care reform is so complex that legislative solutions seem unobtainable. Remember — the Governor has made health care reform his legislative priority. Remember — the public sees health care costs as so important that it ranks only economic recovery above controlling health care costs. Remember — health care reform is needed — the present funding mechanism for Medicaid must be revised by July 1, 1993. Remember — we physicians want health care reform to improve access and affordability to health care. We will have a reformed health care system and a reformed health insurance system.

Our duty and your duty is to see that reform is a positive step for improved patient care. Our duty is to see that reform does not destroy a delivery system that gives superior health care to 86% of the population. Our duty is to see that health care reform maintains the professionalism of physician practice.

With those thoughts in mind, the KMA has presented a health care reform package that is rooted in a set of fundamental principles:

1. Improvements in health care delivery should preserve the strengths of our current system.
2. Health care services should be delivered with high quality at

Inaugural Address — William B. Monnig, MD

- appropriate costs.
3. Patients should be free to determine from whom and the manner in which health care benefits are delivered.
 4. Affordable coverage of appropriate health care should be available to all, regardless of income.
 5. All physicians should be committed to the highest ethical standards in the delivery of health care to patients at reasonable costs.

As your 142nd President, I will work tirelessly with our other leaders to uphold those principles as we help fashion health care reform legislation. And the task will not end with its passage, but rather it will open the way to months and years of work to properly implement it.

“We refuse to passively accept the dictates of a reform movement that will not acknowledge our essential role to the process.”

The Kentucky Medical Association is up to the task. We need every physician's support. We ask you to become involved. Help make every physician a member of the KMA. See the importance of AMA membership. Develop a commitment to the political process, support the political candidate of your choice, but support them wholeheartedly. Our elected

representatives to state and federal government will help formulate solutions to the societal demand for universal access to affordable health care. These representatives need to understand the physician perspective. You and I can and must educate them.

The KMA leadership and staff is here to help you. It is my privilege to be President of the Kentucky Medical Association at such a critical time. I ask for your support, and I accept the challenge. Thank you.

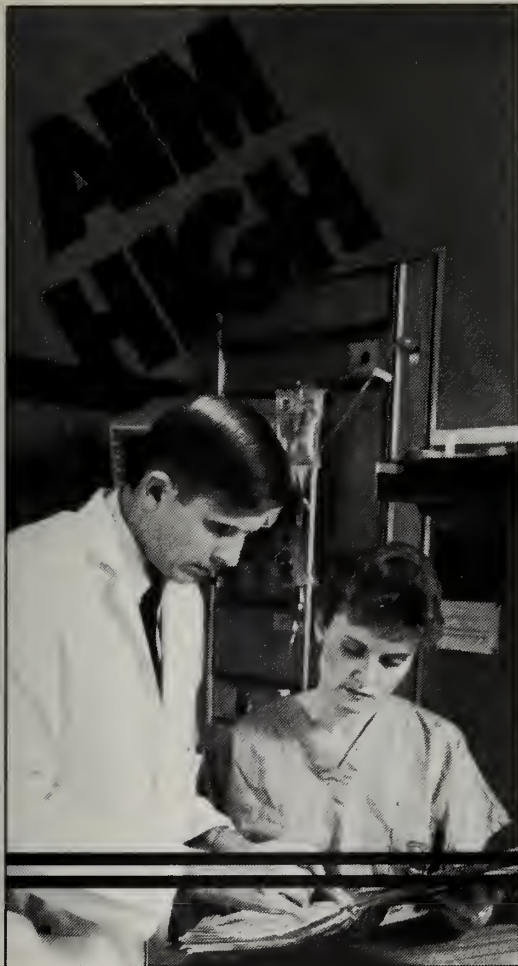
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as he assumed the
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Blood Pressure Changes in Patients With Chronic Obstructive Pulmonary Disease and Hypertension Completing Phase II Pulmonary Rehabilitation

Holmes B. Marchman, MD; Judah L. Skolnick, MD

A retrospective study was conducted evaluating the resting blood pressure (BP) of 160 patients at the onset and upon successful completion of a Phase II pulmonary rehabilitation program. Patients with chronic obstructive pulmonary disease (COPD) exercise at submaximal loads. Patients with both hypertension and COPD would remain hypertensive after a course of pulmonary rehabilitation. The two-tailed t-test was utilized to compare BP at the onset to BP at the completion of the program. No significant differences were found in the following groups: (1) Start and end SBP or DBP of all patients; (2) Start and end SBP or DBP of the 40 (25%) hypertensive patients (HTN-Pts); (3) Start and end SBP or DBP of the 6 (4%) HTN-Pts on anti-hypertensive (anti-HTN) medications; (4) Start and end SBP or DBP of the 34 (21%) HTN-Pts off anti-HTN medications. This study supports the hypothesis that HTN-Pts with COPD participating in a Phase II pulmonary rehab program remain hypertensive. Hypertension in this population should be treated medically.

Introduction

Patients with COPD experience a loss in work capacity as their disease progresses. Pulmonary rehab programs can improve functional capacity as measured by exercise tolerance,¹ peak exercise oxygen capacity, and work outputs.² Because of limitations of respiratory reserve and ventilatory function, these patients exercise at submaximal loads. Thus without an overload stress, hemodynamic functions including cardiac index, stroke volume, and pulmonary vascular resistance remain unchanged.³ Similarly, skeletal

muscle enzymes (citrate synthase, pyruvate kinase, and 3-betahydroxyl coenzyme A dehydrogenase) in trained limbs of COPD patients remain unchanged.⁴

In individuals able to tolerate maximal exercise loads, resting blood pressure may be positively affected. Many studies have demonstrated that regular exercise training lowers BP in both normal subjects and hypertensive patients (HTN-Pts).⁵⁻¹⁰ However, no studies have addressed BP changes in the COPD population. The purpose of this study was to evaluate the resting BP in normotensive and hypertensive patients successfully completing a phase II pulmonary rehabilitation program.

Methods

Charts of 160 patients (82 male, 78 female) successfully completing a Phase II (outpatient) pulmonary rehabilitation program from two centers were reviewed for BP, medications, diagnosis, and number of sessions completed. Only patients with COPD or restrictive lung disease were included. All patients were referred to the centers by their personal physician. Exercise sessions were individualized to meet the needs and capabilities of each patient and included one or more of the following: treadmill, leg ergometer, and/or arm ergometer. Respiratory muscle training was conducted when indicated. Completion of the program constituted meeting the goals designated by the rehab staff.

Hypertension was defined per the American Heart Association criteria: SBP ≥ 140 and/or DBP ≥ 90 . Sitting BP at rest was recorded prior to starting each exercise session. The start BP was the

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Blood Pressure Changes

mean of the first three sessions. The end BP was the mean of the last three sessions. Start and end BP were analyzed with the two-tailed t-test.

Results

The total number of sessions ranged from 8 to 40 with a mean of 17.2 (Table 1). Twenty sessions were completed by 58.1% of the patients, 16.9% completed 8, while 9.4% completed 18 sessions. No significant difference was found in the start or finish SBP or DBP of all patients studied (N = 160). Of the patients with hypertension (N = 40), no significant difference was found in start and end BP. Similarly, no difference was found in start or end BP of those HTN-Pt on (N = 6) or off (N = 34) anti-HTN medications. A comparison of the HTN-Pts on anti-HTN medications to those off medications (treated *vs* untreated) failed to show a significant difference in start and end SBP or in start and end DBP (Table 2).

Discussion

Although several studies examine hemodynamic changes in COPD rehabilitation patients,^{3,4} no

studies specifically address BP changes. Because heart rate, cardiac index, stroke index, and pulmonary vascular resistance do not change with exercise in the COPD population,³ then the BP in HTN-Pts with COPD would not decrease as in HTN-Pts without COPD. These data support the hypothesis that HTN-Pts with COPD will remain hypertensive after a course of Phase II pulmonary rehabilitation.

Most of the anti-hypertensive effect of exercise on HTN-Pts without lung disease occurs at lower levels of activity and in sedentary individuals who increase activity to moderate levels.^{8,9} The COPD population is sedentary due to limitations of ventilatory mechanics and thus unable to exceed submaximal levels of exercise. These data further demonstrate that the COPD population will not experience cardiovascular benefits from exercise, including a reduction in BP, unlike normal subjects and HTN-Pts.

Although the number of pulmonary rehabilitation sessions varied in our study, two-thirds of the patients completed 18 or more sessions. An increased number of exercise sessions would have little effect on BP changes since exercise tolerance is limited by progressive pulmonary disease.

Whether the patient was treated with anti-HTN medications had little apparent effect on end BP. These data suggest that hypertension must be adequately controlled medically since no positive effect on BP is obtained from exercise.

In conclusion, we conducted a retrospective study to evaluate BP changes in the normotensive and hypertensive patient with COPD. Our findings are consistent with other studies showing no change in hemodynamic function at submaximal levels of exercise in COPD patients. Further prospective studies are warranted to further evaluate BP changes in the hypertensive COPD patient enrolled in a Phase II pulmonary rehabilitation pro-

Table 1. Sessions completed, number of patients, percentage of total patients.

Sessions	Pts (%)
8	27 (16.9)
9-15	9 (5.6)
16	7 (4.4)
18	15 (9.4)
19	5 (3.1)
20	93 (58.1)
17,22,40	3 (1.8)
	160

Table 2. Comparison of Beginning BP With End BP

	N	Systolic BP			Diastolic BP		
		t	degrees of freedom	p	t	degrees of freedom	p
Total Grp	160	-0.12	159	0.906	1.07	159	0.286
HTN	40	-0.74	39	0.466	0.83	39	0.412
HTN untreated	34	-0.89	33	0.379	1076	33	0.088
HTN treated	6	0.42	5	0.695	-0.67	5	0.533

Significance: $p < 0.05$.

gram. Until further studies are available, clinicians should medically control hypertension in this population.

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Treatment of Traumatic Pancreatic Pseudocyst by Percutaneous Aspiration

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We describe the nonoperative management of a traumatic pancreatic pseudocyst following blunt trauma in a child. This problem can be accurately diagnosed and followed with computed tomography or ultrasound. Percutaneous aspiration of unilocular pancreatic pseudocysts in children provides an attractive alternative to operative treatment in selected cases.

Introduction

Blunt abdominal trauma is the most common cause of pancreatic injuries in children. The following case illustrates our institution's approach to the management of childhood traumatic pancreatic pseudocysts.

Patient and Methods

A 6-year-old boy was admitted to the hospital after he was injured while attempting to cross a ditch on his bicycle. He fell onto the left side of his chest and was struck in the mid-abdomen by the bicycle handlebar. Immediately following the accident, he exhibited no physical signs of injury and never lost consciousness. He went to bed as usual, but was awakened by nausea. Several episodes of bilious emesis associated with abdominal pain prompted his mother to seek medical attention 12 hours after injury.

He was seen in the Emergency Department of a local hospital where he was noted to have epigastric abdominal tenderness, with voluntary guarding in the upper and lower left quadrants. Abdominal and chest films were normal and serum amylase elevated. The patient was transferred via helicopter to our facility at Kosair Children's Hospital.

Physical examination on arrival revealed an alert and cooperative child with a nasogastric tube in place. Examination of the head, neck, lungs, and heart were normal. The abdomen was

scaphoid, and a small contusion was present inferior to the left costal margin. Normal bowel sounds were present and no masses were palpated. There was no abdominal tenderness or guarding noted on examination at our institution. Rectal examination was normal, and a stool sample was reported negative for occult blood. An upper gastrointestinal series to rule out duodenal hematoma appeared normal. The hematocrit was 38%, the white blood cell count 16,000, and serum amylase was 294 U/L (normal = 25 to 115 U/L). Computed tomographic (CT) scan of the abdomen showed free fluid in the left paracolic gutter and an area of decreased attenuation in the pancreatic neck. The patient was treated with intravenous fluids, bowel rest, and nasogastric decompression.

On the second hospital day, the patient complained of mild epigastric abdominal pain and tenderness to deep palpation was noted in the left upper quadrant. Serum amylase increased to 723 U/L and serum lipase was 2994 U/L. A repeat CT scan of the abdomen enhanced with oral and intravenous contrast (Fig 1) confirmed an area of low attenuation at the junction of the body and tail of the pancreas. This was consistent with pancreatic laceration.

The lack of significant clinical signs or symptoms prompted conservative management of the injury with intravenous alimentation. The patient continued to experience mild abdominal discomfort without nausea or vomiting. He was kept at bed rest for 7 days. Serum amylase peaked at 723 U/L and then consistently decreased during the period of observation.

With resolution of clinical findings on the patient's 7th day in the hospital, a clear liquid diet was instituted and well-tolerated. This resulted in an elevation of serum amylase to 608 U/L and serum lipase to 3661 U/L, although the patient remained asymptomatic.

A CT scan of the abdomen with oral and intravenous contrast was repeated the same day,



revealing the development of a cystic mass in the retroperitoneum just anterior to the body and tail of the pancreas (Fig 2). The mass appeared to extend inferiorly within the anterior perirenal space to the level of the midpole of the left kidney. The anterior aspect of the mass abutted the posterior wall of the stomach. The mass was 6 cm in its greatest dimension ($6 \times 2.8 \times 5$ cm).

On day 14, the patient was discharged from the hospital and placed on home hyperalimentation with limited physical activities. Two weeks later a follow-up CT scan demonstrated an increase in pseudocyst size ($6 \times 4 \times 5.5$ cm). The pancreas was otherwise structurally intact, and the patient continued to be asymptomatic.

He was readmitted for CT-guided aspiration of the pseudocyst 28 days following initial injury. Using a percutaneous transgastric approach with a 22-gauge spinal needle, the pediatric radiologist successfully aspirated 34 mL of clear fluid with the patient anesthetized. A post-aspiration CT showed near total resolution of the fluid collection (Fig 3A). Laboratory analysis of the aspirate detected no amylase, red blood cells, or white blood cells. The culture did not grow organisms.

Forty-six days after the original injury (18 days after aspiration), a follow-up CT scan demonstrated a minor recurrence of the pseudocyst, but the overall volume was less than half that of the original pseudocyst. The patient's serum amylase had decreased to 196 U/L and he was asymptomatic.

Oral feedings were reinstituted 49 days following the injury, the intravenous alimentation was discontinued, and the patient discharged. A follow-up CT scan on post-injury day 62 demonstrated complete resolution of the recurrent pseudocyst (Fig 3B).

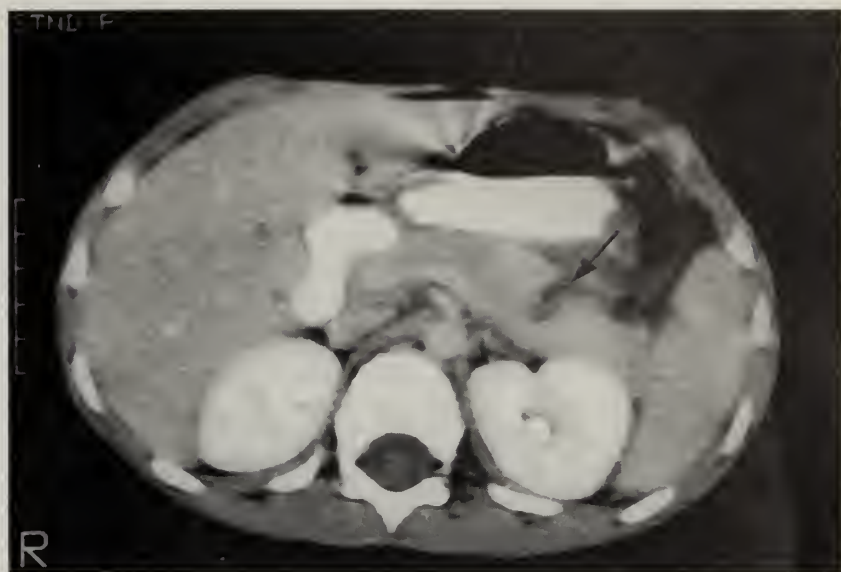


Fig 1 — A computed tomogram following admission to the hospital. The study shows a probable pancreatic laceration (arrow).

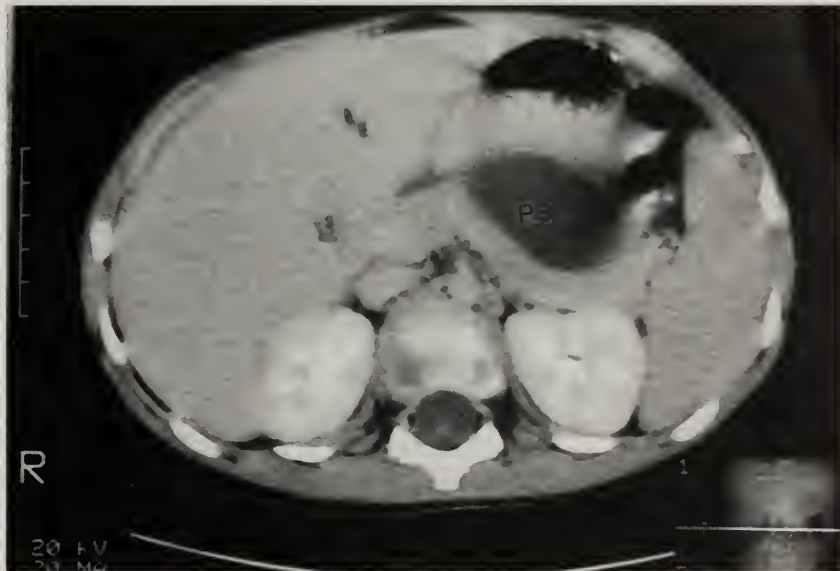


Fig 2 — A computed tomogram 3 weeks following the injury demonstrates a pancreatic pseudocyst (PS) that is $6 \times 4 \times 5.5$ cm.

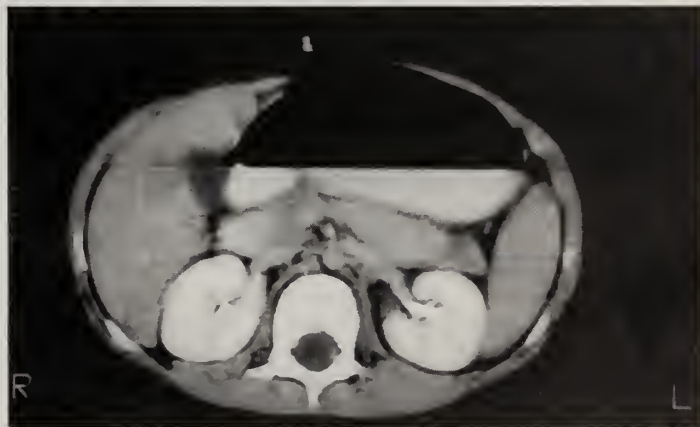
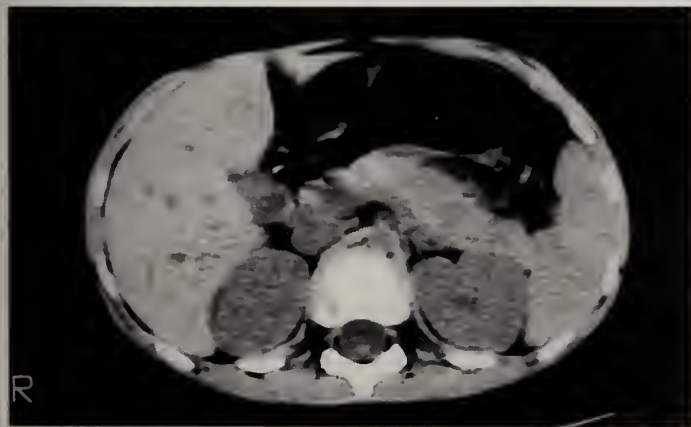


Fig 3 — These computed tomograms show (A) resolution of the pseudocyst immediately following percutaneous aspiration and (B) complete resolution 2 months following injury.

Traumatic Pancreatic Pseudocyst

Discussion

Rate of Occurrence. Injury to the pancreas has been reported to occur in 1% to 20% of patients who sustain blunt abdominal trauma. Burnweit et al¹ noted that 45% of children in their study who were treated for pancreatic trauma developed pseudocysts. Warner et al² treated nine children over 10 years for traumatic pancreatitis, which resulted in pseudocyst formation in 78% of patients. Bass et al³ reported 26 cases of blunt pancreatic trauma in children over a 10-year period and found that 38% developed pseudocysts.

Pseudocyst formation occurs when pancreatic fluid leaks, usually into the lesser sac, and is encapsulated with a fibrinous exudate. The pseudocyst does not possess an epithelial lining. When pseudocysts develop in children, they differ greatly from those in adults. Childhood pseudocysts are acute, thin-walled, and ordinarily are not related to underlying pancreatic duct obstruction or associated ductal disease.² Pancreatic pseudocysts in children are usually acutely symptomatic and require earlier treatment than those in adults. The different pathogenesis in children allows more rapid resolution and reduces the likelihood of recurrence and complications following drainage procedures.³

Mechanism of Injury. Several recent case series of pancreatic pseudocysts in childhood delineate the mechanism of injury. Burnweit's series of 13 patients with pseudocysts found 38% to be bicycle-related and 23% to result from pedestrian versus motor vehicle accidents.¹ In a Jaffee et al⁴ study of seven patients, 29% were bicycle-related, and 29% were due to horse-related injuries. In the Bass series, 42% of pancreatic injuries were bicycle-related as opposed to the Warner series, where the majority of patients (56%) were in motor vehicle accidents and only one was a handlebar injury.^{2,3} Additional causes of pancreatic pseudocyst include motorcycle accidents, all-terrain vehicle accidents, and child abuse.

Diagnosis. A clinical diagnosis of traumatic pancreatic injury in children depends on a history of trauma with associated abdominal pain, vomiting, nausea, fever, or back pain. Signs on physical examination may include fever, tachycardia, hypotension, abdominal distension, tenderness or mass, and periumbilical discoloration.^{2,3,5} The most important laboratory finding to diagnose pancreatic injury is hyperamylasemia, and serum amylase has been found to be elevated in 91% of patients with blunt pancreatic trauma.^{2,4}

Radiographically, pancreatic pseudocyst may be diagnosed by ultrasonography or computed tomography. The sonographic diagnosis of a pseudocyst requires identification of an anechoic mass with good through-sound transmission and well-defined margins. The CT diagnosis includes visualization of a nonenhancing, fluid density mass with distinct margins. Williford et al⁶ compared the accuracy of ultrasound versus CT in the diagnosis of 54 patients who were examined to rule out pancreatic pseudocyst. Computed tomography with oral and intravenous contrast correctly identified 23 of the 24 pseudocysts. The missed pseudocyst was 1.5 cm in diameter and located in the head of the pancreas. Real-time sonographic studies correctly diagnosed 18 of the 24 pseudocysts. However, in 10 cases of correct diagnosis, the findings were incomplete relative to CT findings. The authors of the study recommended initial CT evaluation, and CT evaluation a few days before surgery. Sonography, when correlated with CT findings, was more useful to monitor the progress of the pseudocyst.⁶

The differential diagnosis of pancreatic pseudocyst includes cystic pancreatic lesions. Without a history of trauma or the benefit of a series of CT examinations, non-neoplastic lesions such as pancreatic abscess, infected pancreatic necrosis, retention cyst, and congenital cyst may be misdiagnosed as pseudocyst. It is not uncommon to have an occult pancreatic cystic lesion defined incidentally following a traumatic episode. Radiologic differentiation of pseudocysts from cystic neoplasms may be possible on CT, especially when correlated with risk factors, history, and laboratory findings. A cystic pancreatic neoplasm is more often multiple, located in the body or tail of the pancreas, has a wall-thickness greater than 1 cm, and is often less calcified than are pseudocysts.⁷

Treatment. The initial treatment of recognized uncomplicated isolated pancreatic injuries is uniformly nonoperative. During the first several weeks following a pancreatic injury with pseudocyst development, management at our institution includes nasogastric drainage, bowel rest, and intravenous alimentation. Antibiotics are not routinely included in this regimen.

Burnweit et al¹ reported that 46% of pseudocysts resolved with no further treatment over a mean of 24 days. Warner et al² noted the spontaneous resolution of 29% of pseudocysts. Fifty percent of pseudocysts spontaneously resolved over a period of 4 to 8 weeks in the Bass et al³ study.

A retrospective review of 75 adult cases of pancreatic pseudocysts documented by CT demonstrated the size of the pseudocyst correlated directly with the eventual need for operation. If pseudocyst size was greater than 6 cm, 67% of patients required surgical treatment. Smaller pseudocysts required surgery in 40% of cases. An abdominal mass on physical examination was present more frequently in the operated group.⁸ Enlarging symptomatic pseudocysts present for more than 6 weeks generally have an unacceptably high complication rate and require drainage procedures. Complications include infection, hemorrhage, bowel obstruction, bowel perforation, and pseudocyst rupture.

External drainage, cystogastrostomy, and distal pancreatectomy with excision of the pseudocyst are surgical options depending upon pseudocyst location and potential complications. A recently described alternative to operative management of pancreatic pseudocysts is percutaneous aspiration with or without insertion of a drainage catheter. Ultrasound or CT guidance is used to localize the pseudocyst. Typically, intramuscular or intravenous sedation is employed, with general anesthesia reserved for young children or particularly difficult cases. Either a direct or transgastric percutaneous approach may be employed, depending on pseudocyst location.⁹

A pigtail catheter may be left in place for continued drainage. In adults, a single aspiration procedure has a high recurrence rate.¹⁰ Due to the usual absence of ductal involvement in pancreatic pseudocysts of children, a single aspiration might, in theory, be successful. A CT, sonogram, or sinogram demonstrates the success of the procedure. Potential complications include bleeding, bowel perforation, pneumothorax, empyema, or persistent fistula.

Burnweit et al¹ used percutaneous transgastric drainage in 38% of patients with pancreatic pseudocysts (average size, 10 cm). The catheter remained for an average of 12 days. Thirty percent of patients in the Bass et al³ study underwent percutaneous drainage for 13 to 50 days. Cath-

eters were removed when drainage was scant and the patient tolerated a regular diet. There were no complications and no recurrences reported.^{1,4}

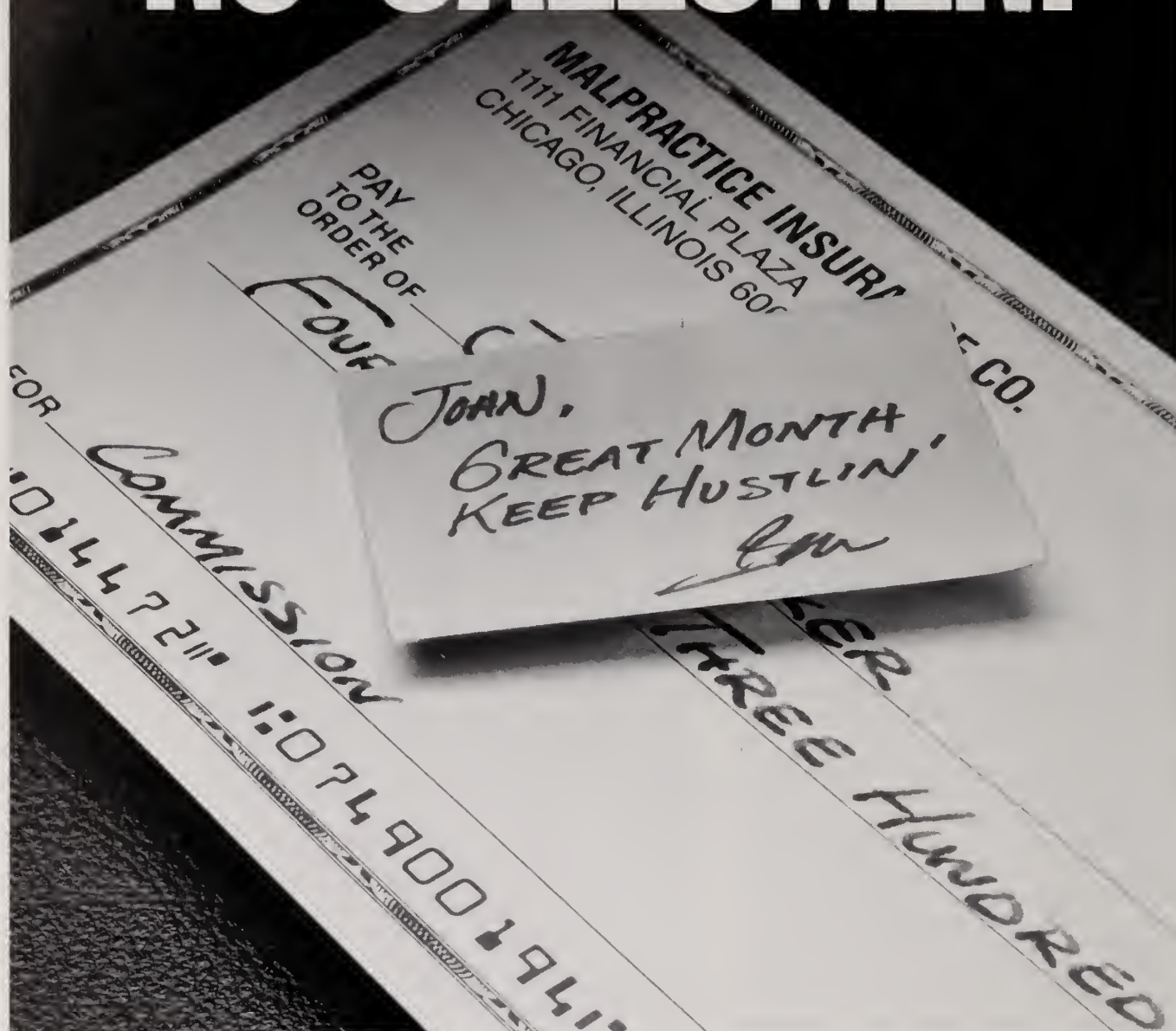
Summary

We described the nonoperative management of a traumatic pancreatic pseudocyst in a young child. With the rationale that ductal involvement is unusual in childhood pancreatic pseudocysts, aspiration without continuous drainage was employed. Therapy was successful as evidenced by complete resolution of the pseudocyst on computed tomography. We recommend this approach as an alternative in selective cases of traumatic pancreatic pseudocyst in children.

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Maternal Mortality Report

Susan M. Cox, MD; John Petry, MD; John W. Greene, Jr, MD

A 20-year-old married G1P0 was first seen August 22, 1989, at 21 weeks gestation for prenatal care. She denied a history of hypertension, diabetes, or other medical problems. A pilonidal cyst was removed in childhood and there were no other surgeries. Family history was also negative for illnesses such as diabetes, hypertension, or cardiac problems. She had no known allergies. There was no history of alcohol, drug abuse, or tobacco use. At the initial visit she weighed 184 pounds (83.6 kg) and was 5 ft 4 in (175.2 cm) in height.

On September 8, 1989, at 23 weeks gestation, she was seen in the Emergency Room complaining of headaches, nausea, vomiting, and backache. Uterine contractions were present. The examination revealed the cervix to be short and finger tip dilated. She was placed on bedrest and given terbutaline 2.5 mg orally three times per day. She was also given Vistaril 25 mg to take every 6 hours for her nausea and vomiting. She was seen again on September 12 for similar complaints, and an electrocardiogram was obtained which read as normal except for tachycardia. Ultrasound examination revealed a normal fetus at 24 weeks gestation. She was again seen on September 22, by a nurse midwife. Uterine irritability was described as only occasional. Her blood pressure was normal and she was maintained on the terbutaline. Follow-up examination on October 6 revealed her weight to be 196 pounds, Hct 30 vol %, Hb 11 grams, and her glucose 162 mg/dl. The terbutaline was stopped. A 3-hour glucose tolerance test revealed the following results: fasting 91 mg/dl, 1 hour 163 mg/dl, 2 hour 143 mg/dl, 3 hour 113 mg/dl. A proper diet was then reinforced.

At the subsequent visit on October 30, her maternal weight was 198 pounds, blood pressure was 130/70, and she complained of headache and dizziness. The pregnancy was then 32 weeks by ultrasound. Examination of the cervix was described as closed, long, and the vertex at -2 station. She was begun on one baby aspirin daily for pre-eclampsia prophylaxis.

For the next 6 weeks, nausea and vomiting persisted. The patient also continued to complain of headaches. Her diastolic blood pressure was noted to be in the 90 range. Her weight remained stable, urine protein was negative, and edema was mild.

On December 11, her weight was 198, B/P 120/64, and she complained of nausea, vomiting, and headache. She also reported less fetal movement. Ultrasound revealed the vertex floating with normal amniotic fluid volume. NST was reactive.

At 35 weeks gestation she was admitted to the hospital complaining of nausea, vomiting, and shortness of breath. Vital signs showed a weight of 205 pounds, pulse 120, and blood pressure 100/60. Shortly after admission she was transferred to another medical center for studies to rule out pulmonary embolus. A ventilation perfusion scan revealed low probability of pulmonary embolus. The echocardiogram revealed diffuse hypokinesis, left ventricular dilation, mitral regurgitation, and poor wall motion. Swan Ganz catheter showed a high pulmonary artery pressure and central venous pressure, consistent with peripartum cardiomyopathy.

On December 16, an emergency cesarean section was performed for deteriorating maternal and fetal condition. Anesthetic induction was complicated by hypertension and a cardiopulmonary arrest. She responded to CPR and the infant did well.

The patient's postpartum course was complicated by endometritis and retained products of conception. The patient was treated with erythromycin, gentamicin, vancomycin and a D & C was performed. Six days post cesarean section a superficial wound dehiscence occurred.

She was transferred to a teaching center for cardiac evaluation for possible transplant secondary to peripartum cardiomyopathy. At this time, exam revealed her to be on a ventilator, alert, and able to follow commands. She was breathing at a rate of 22 (AC set at 16), B/P 90/50, T-102. EENT normal except for healing vesicular lesions

Maternal Mortality Report

on the lips. There was no palpable adenopathy. There were rales and rhonchi throughout both lung fields. Cardiac exam revealed tachycardia with a regular rhythm. No murmurs were appreciated. The abdominal incision from the C-section was opened and revealed clean granulation tissue. The bowel sound was hypoactive. There was no clubbing, cyanosis, or edema of the extremities. Pulses were 2+ and symmetric in all extremities.

Laboratory data revealed a WBC of 21.6, HB 9.5, Hct 28.5, platelets 587,000, PT 12.9, PTT 28.1, Sodium 133, Potassium 5.1, Chloride 99, Bicarbonate 22, BUN 32, Creatinine 0.9, and Glucose 124.

Secondary to persistent fever a complete reevaluation was initiated. Cultures were taken and acyclovir was begun for the herpetic lesions of her lips. Pulmonary infiltrates on x-ray raised concern about a viral pneumonitis. The patient remained on pressor agents to maintain her blood pressure.

Thirteen days postoperatively she developed bilateral lung infiltrates, with the possibility of infection or cardiogenic etiology considered. Sepsis was suspected when she began to deteriorate further with metabolic acidosis and poor oxygenation. She continued to deteriorate with decreasing responsiveness, increasing temperature, and an arch pattern on the chest x-ray. The patient became hypotensive, and despite multiple pressors and an intraortic balloon pump, she continued to deteriorate. She died on postoperative day 14.

A limited autopsy was permitted on the chest and abdomen. Significant findings included:

1. peripartum cardiomyopathy
2. massive bilateral lobular pneumonia
3. pleural effusions
4. cholelithiasis
5. postpartum uterus recently sutured

The Maternal Mortality Committee studied this case and classified it as an obstetric direct — with nonpreventable factors.

Comment

Peripartum cardiomyopathy is defined as cardiomyopathy that develops during the last 4 weeks of pregnancy or within 6 months of delivery. Importantly, women who develop this entity have no known previous cardiac disease, and other causes of cardiac failure must be excluded such as amniotic fluid embolism, severe pre-eclampsia,

and pulmonary edema associated with steroids or beta-mimetics.

The incidence of peripartum cardiomyopathy is between 1:1500 to 1:4000 deliveries in the United States. The peak incidence occurs during the second month postpartum with an increased incidence noted among older, multiparous black females. Other risk factors include familial recurrence, twinning, and patients with pregnancy induced hypertension. The signs and symptoms of left ventricular dysfunction are present and include dyspnea, fatigue, and pulmonary and peripheral edema. Classic evidence of congestive heart failure is noted on physical examination and includes a jugular venous distension, an S3 gallop, and rales. Chest X-ray reveals cardiomegaly and pulmonary edema, and EKG demonstrates left ventricular and atrial dilatation. Echocardiography will show dilatation of the left ventricle with reduction in systolic ejection fraction.

Therapy includes diuretics, digitalization, sodium restriction, and bedrest. In cases that are refractory to the above measures, after load reduction with hydralazine or nitrates may be of benefit. Steroid immunosuppressive therapy is controversial. Endomyocardial biopsy has been suggested to exclude inflammatory myocarditis. The histologic picture involves a non-specific cellular hypertrophy, fibrosis, increased lipid deposits, and degeneration.

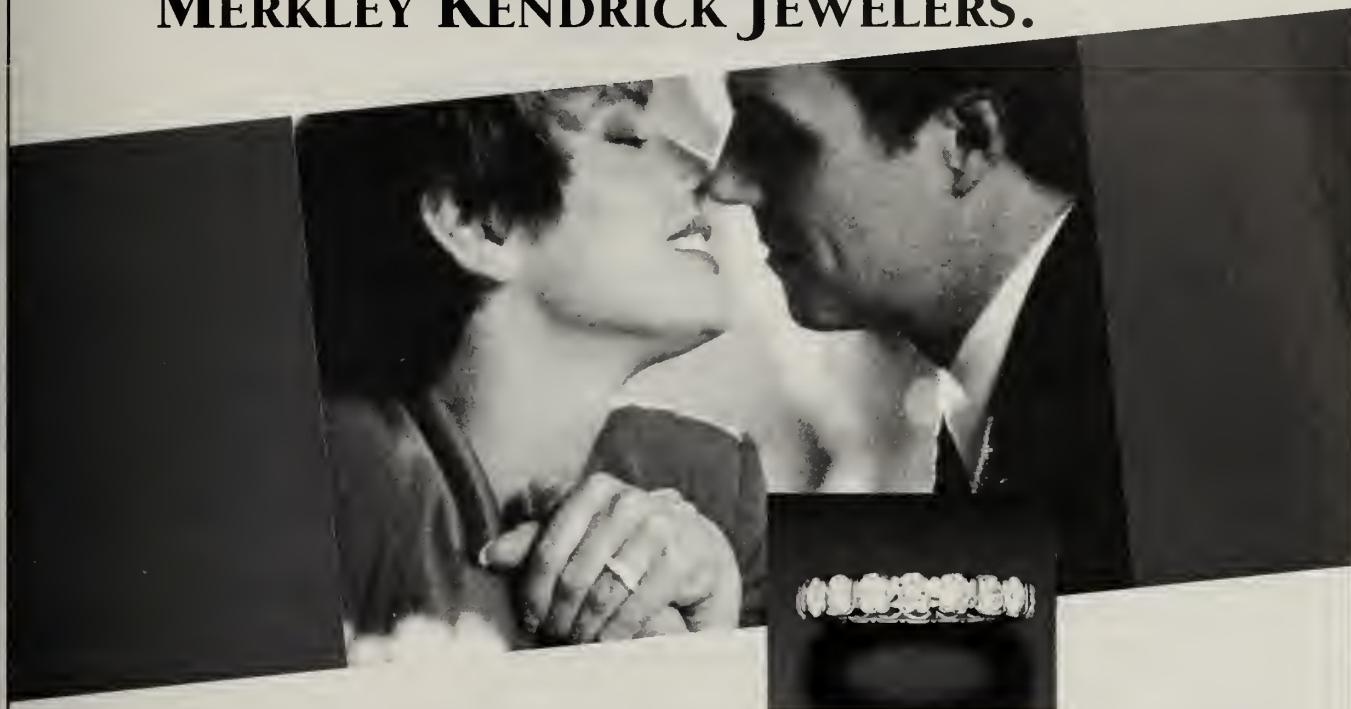
Those that survive will resume normal left ventricular function within 3 to 6 months. The mortality ranges from 20% to 60% with this entity, and cardiac transplant must be considered.

An unfortunate feature of peripartum cardiomyopathy is a recurrence in 35% of future pregnancies. If the patient's cardiac size returns to normal within 6 months, the mortality rate with subsequent pregnancies is 11% to 14%, but if they had persistent cardiomegaly the mortality rate approaches 80%. Therefore, preconceptual counseling is of great importance, and pregnancy is contraindicated in patients with persistent cardiomegaly.

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For over 160 years we have worked to be the best. It's a good feeling to finally have proof we've succeeded. A complete copy of the Morrison & Morrison, Ltd. Survey Report is available at our store for your inspection.

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* Morrison & Morrison, Ltd. Fine Jewelry Purchasers Survey, 1991



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The Hospital Medical Staff Section Twentieth Assembly Meeting December 3 - 7, 1992 Opryland Hotel Nashville, Tennessee

**Highlights of the Interim Meeting will include
an educational program on:**

**Part I:
A Futurist's Picture of
Health Care 2000**

A highly recognized consultant in health care issues will provide his perspective of the factors that will influence the reform of the health care system in the decades to come. Having painted a picture of Health Care 2000, the futurist will respond to questions of a reactor panel which will focus on:

- the role of organized medicine in framing the future health care delivery system,
- the role physicians will play in shaping the future and assuring adequate access to high quality health care services, and
- the impact that anticipated changes in the health care delivery system will have on the hospital medical staff's relationship with the community outside the hospital setting, including the payers.

**Part II:
Physician / Hospital
Organizational Models
for the Future**

The relation of the hospital with members of its medical staff will be substantially impacted by the forces that are shaping national health care policy and the health care delivery system of the future. The HMSS Representatives will learn:

- what some states are doing to serve as "laboratories" for alternative health care delivery systems,
- what the AMA is doing to study and advise physicians on the appropriateness of various physician / hospital organizations, and
- what one consultant anticipates will ultimately be the prognosis for organizational relationships between health care providers.

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Community Classrooms

With the advent of health care reform and educational reform in the state of Kentucky and in the nation at large will come major changes in the logistics of delivery of both health care and education. Significant efforts will be directed towards the augmentation of primary care delivery in the community and towards the enhancement of local school-based decision-making. New paradigms for funding will be investigated for both. Access to services and technology will be critical for the success of both endeavors.

While there exist numerous similarities in the challenges facing both health care reform and educational reform, there is one major area of overlap between the two — health education. As health education grows into one of the most integral aspects of everyday life in the years to come, perhaps the most critical aspect of its development will involve the interface between the community healthcare and health education sector and the community schools. Traditionally, health

education efforts have been diffused and dependent upon the efforts of individual agencies and interested individuals within the community. School-based health education has often occurred in a cloistered fashion, without the input and expertise of the many skilled educators in the community. Both community health education and school-based health education have often lacked the interest and contribution of the medical community. The future must involve all three.

As with health care, health education must be provided where it can best be implemented and where it can be most effective. School health education will need to be provided within the schools and involve the efforts of community health educators and physicians. Similarly, schools will need to successfully interact with and accommodate existing community health education resources and emerging medical information in order to insure comprehensive coverage of health issues and to prevent the costly duplication of services inherent in the development

of a sequestered school health program.

As with health care, the funding of health education will require a new and innovative merging of public and private monies. Small and large businesses alike must come to understand the huge potential benefits of funding health education for their employees and their communities and invest accordingly. Public funds must continue to be available for the comprehensive delivery of all health education information necessary to insure an informed population. Voluntary efforts and charitable resources will need to continue and become more integrated and less segmented in order to provide optimal education for all.

Ultimately, we must all come to see the need to create "community classrooms" which blur the boundaries between public and private, community and school, voluntary and paid. If we can, then both the health care and education reform missions will be well served.

Daniel W. Varga, MD

THE UNITED STATES ARMY RESERVE HEALTH CARE PROFESSIONALS BONUS TEST PROGRAM

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Leadership Training Offered by AMAA

Our National Medical Organization

The AMAA sponsored Leadership Confluence is held twice each year in Chicago at the Drake Hotel. It is one of the most intense workshops available to help in educating and training leaders of a volunteer organization. AMAA Leadership Confluence dates for the 1992-93 year are October 18-20, 1992, and January 31-February 2, 1993.

Each state Auxiliary's allocation for participation is based on its AMAA membership for the previous year. Since Kentucky's AMAA membership had declined for several years, only six county auxiliary presidents-elect had the opportunity to attend these leadership workshops. Two years ago the state implemented a rotation schedule for Kentucky's 13 county presidents-elect to attend. This year we will have two additional county presidents-elect participating in this training opportunity. These Leadership Confluences have proven to be so vital, however, that some counties are budgeting the extra expense so their presidents-elect can continue to participate at the county's expense. I'm pleased to announce that AMAA membership has increased in Kentucky. Your continued support of these leaders through your AKMA and

AMAA membership is greatly appreciated.

The following county presidents-elect will be attending Leadership Confluences in October:

Northern Kentucky:

Dale Due (Mrs Tom)

Daviess County:

Mary Havelda (Mrs Christopher)

Fayette County:

Janet Schwartz (Mrs Richard)

Henderson County:

Ann Cave (Mrs John)

Hopkins County:

Shang Liao (Mrs Henry)

Jefferson County:

Debbie Bruenderman
(Mrs David)

These county presidents-elect will be sharpening their organizational and management skills and obtaining program suggestions appropriate for their own county auxiliary. Since every available moment is important, speakers and resource persons have been chosen carefully and are experts in their respective fields.

The first day and a half, everyone will attend plenary sessions on the topics of: Leadership Style and Image, Legislative Update, Medical Marriage and Parenting. The next day and a half participants can choose four



Gloria Griffin

"I encourage all physician spouses to join us and take advantage of what our state and national auxiliaries have to offer as we are all 'Working Today For A Better Tomorrow.'"

breakout sessions allowing them an opportunity to strengthen their leadership abilities in:

- Getting Media Mileage From Your Projects
- When The Spotlight Is On You
- Motivating . . . And Working with . . . Volunteers
- Misuse and Abuse of Drugs
- Parliamentary Procedures
- Teen Sexuality and AIDS
- Family Violence
- Women's Health Issues

As you can see, the confluence program is planned to provide participants with as much information as possible. Audio cassette tapes of these sessions are also available for participants to purchase and share with their county membership. The AMAA resource center will feature a complete assortment of publications available from national headquarters

to all AMAA members. The opportunity to interact with colleagues from around the country starts at 7:30 AM each morning and continues through dinner each evening.

The AMAA Leadership Confluence is just one of the many benefits you receive from the federation of county, state, and national medical auxiliaries. Presidents-elect are returning from AMAA Leadership Confluence energized, informed, and committed to "Working Today For A Better Tomorrow." They will be interacting with other physician spouses from across the nation, while setting and implementing goals for the future of the auxiliary. AMAA continues to contribute to the overall auxiliary effort as advocates for medicine. Every physician's spouse should

consider supporting all levels of the auxiliary by belonging and participating on the county, state, and national levels. By participating in the Auxiliary and its programs, members demonstrate support of their spouse's profession. I encourage all physician spouses to join us and take advantage of what our state and national auxiliaries have to offer as we are all "Working Today For A Better Tomorrow."

For information on AKMA and AMAA membership contact:
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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

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Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral alpha-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

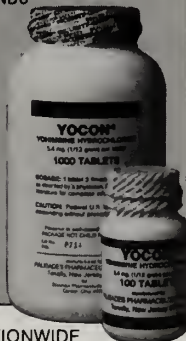
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

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Donz Alexandre

William B. Monnig, MD

KMA's President 1992-93

"My family always respected physicians. We could walk three blocks up the street to our family doctor — he was a part of the neighborhood — and he was our family doctor *forever*. He left a very favorable impression."

His sincerity as he spoke indicated that this respect and favorable impression laid the foundation that culminated in William B. Monnig, MD, becoming a physician, and one of the most respected and dynamic leaders of the Kentucky Medical Association. For sure, the affairs of organized medicine in Kentucky continued in good hands as this highly qualified Northern Kentucky urologist was installed as the Association's 142nd President at the Annual Meeting on September 16.

Growing up in a lower middle-income neighborhood in Cincinnati, Ohio, it was an improbable ambition for this second of six children to become a physician. However, the work ethic to achieve this goal was instilled at an early age. "Everyone in my family worked. I worked from the time I was in third grade, first in a bowling alley setting up pins, and then in a drug store. My dad was a blacksmith and owned a small welding shop. My mother started working full time when my youngest brother was 6, and she is still working."

As a young student, Bill Monnig did not seem destined to become a physician. "Only two people from my

8th grade graduation went to college. I attended St. Xavier High School in Cincinnati. Academically I did very well there, was very involved, and enjoyed it. I was a swimmer. I wanted to attend college and swim. I ended up at the University of Cincinnati because it was affordable, had a swim team, and I had scholarships to go there." Dr Monnig continued with a comment that will not surprise his colleagues. "I was very, very involved in college — in fraternities, honorary societies, and on the swim team.

"About the end of my junior year, I decided to apply for medical school, and the only place I applied was at the University of Cincinnati. No one in my family was a doctor; no one in my life at that point was involved in medicine at all. To further complicate my decision, there were job recruiters on campus. Proctor and Gamble offered me a position in their management program upon graduation at a salary of \$20,000 a year. That was in 1965, and I thought, 'Boy, that's a lot of money.' " But before choosing the business world, Dr Monnig's destiny to become a physician was rekindled, and he became totally committed. "It wasn't much of a choice — I really wanted to go to medical school."

After graduating from the University of Cincinnati College of Medicine in 1969, he completed an internal medicine internship at the University of Illinois in 1970, then returned to the University of

Cincinnati to fulfill a surgical residency from 1970 to 1971, and a urology residency from 1971 to 1974.

Introduction to Organized Medicine

This physician's careful voice and mild-mannered demeanor mask a complex man. He has proven his tenacity in worthwhile pursuits. This came to the forefront when, with an amused expression, Dr Monnig related his introduction to organized medicine. "I started a solo urology practice in 1974 in northern Kentucky, having to deal with a fee profile of urologists who had been in practice for 34 and 43 years. When I learned what I would be reimbursed, I didn't think I could make ends meet, so I sought redress for my grievances. Several physicians, including Dr Tom Heavrin and Dr Lee Hess, said, 'Well, the Kentucky Medical Association is the place to take your complaints.' So, in 1975, I drove down to the KMA House of Delegates meeting. I wasn't a delegate, I wasn't anything. I just wanted to see what was going on. As it turned out, one of the delegates from northern Kentucky didn't show up so they made me an honorary delegate, and I started working from that time forward." The amused expression took on a tinge of humbleness as this new leader continued to reminisce. "I did espouse a significant number of issues which were contrary to what the

leadership of the Kentucky Medical Association was espousing. They were tolerant of me, and then I worked my way through the system."

Dr Monnig does not boast of his exemplary service through the years, but for this very busy physician, "worked my way through the system" translates to service as an Alternate Delegate in 1975-76; Delegate 1977-84; 8th District Trustee 1984-90; simultaneously as Chairman of the Board of Trustees, Chairman of the Executive Committee of the Board of Trustees, and as a member of the Quick Action Committee 1987-90; Vice President 1990; President-Elect 1991; and now President in 1992. His *curriculum vitae* also shows a lengthy list of professional and community involvement during these years.

This record indicates that the physicians of Kentucky are definitely better off today because Dr Monnig "worked his way through."

Major Thrust for 1992-93

Bill Monnig has impressive powers of concentration. He is very analytical and thoughtful as he discusses his goals, and without hesitation, he glides smoothly from issue to issue.

"Health care reform is certainly going to be the major thrust for this year.

"Aside from this issue, my personal goal for the year is to see the Kentucky Medical Association accepted as *the* professional association of physicians to decide health care issues. Both within the association — which will mean informing the membership and having the membership buy off on the idea that the leadership of the Kentucky Medical Association will be acting as their liaison with all outside interests — and convincing the outside interests that the Kentucky Medical Association is *the* professional association for physicians and will be speaking for all of the physicians of

Kentucky when it comes to any health care issue."

The State Legislature and Health Care Reform

Dr Monnig examines the issues with diagnostic rigor so that when he speaks, in his deliberate way, he knows exactly what he's talking about.

"Health care access and health care affordability were very hot topics with the legislature, as evidenced by the Governor's call for a special session. The legislature is interested in health care issues, but it seems their main driving force is on cost issues. They haven't adequately addressed lifestyle issues that definitely need addressing in Kentucky, and that the Kentucky Medical Association has been advocating for years. This is a very frustrating part of our legislative package.

"It's going to be extremely difficult for the Kentucky Medical Association to address the issue of physician income in relationship to health care reform. It is certain that every adversarial group will address this issue, regardless of our argument that we account for only 19% of all health care dollars. The anecdotal references to physicians making \$750,000 or \$1 million are just that — they are anecdotal. But, we really can't explain them. My response to the critics will be, if you give us the opportunity and the legal immunity to deal with these issues, we will rectify them. If they are unwilling to do that and they broaden the attack to say they wish to regulate all physicians' incomes, we're going to have to fight very hard to demonstrate that physicians *are* worth a significant amount of money, and we need to be able to encourage our brightest students to enter medicine. That doesn't mean they have to make the best salaries in the world, but they can reasonably expect to make good salaries."

KMA's Lobbying Effort

"The Kentucky Medical Association has the best lobbying methodology and people of anybody in the state. We *are* the envy of the state. Our lobbyists are extremely effective. The other reason KMA is so successful is that, first of all, we are advocates for patients, *and* we have developed a grass roots communication with our legislators. That probably began in earnest when tort reform was the big issue in the 70s. Dick Hench was on that commission and spent a whole year going to committee meeting after committee meeting, at a tremendous personal sacrifice, to deal with tort reform.

"Involved physicians have made and are making a difference in Frankfort and Washington. Wally Montgomery, our state legislative chairman, lives in Paducah and goes to Frankfort every week when the legislature is meeting to actively lobby with our lobbyists with the state legislators. There is no question that he has a tremendous impact and has made a sacrifice for the other physicians of our state.

"Dr Montgomery and KMA staff under the direction of CEO Bob Cox do an excellent job of communicating the legislative issues — the things we need to be thinking about, and the results of our efforts. They focus our constituency, our physicians, and our spouses on what issues we need to address — and it's done on a weekly basis when the legislature is in session. The 'Communicator,' legislative alerts, 'Legislative Handbook' that lets people know who their legislators are and how to contact them, and the 'Legislative Report' at the end of the session have been excellent. We do a superb job compared to almost any other organization that I've ever seen. I don't know how it could be improved.

"Russ Travis's involvement with



KMA President Monnig is pictured with family members in attendance at his Inauguration — (L to R) wife Donna, Dr Monnig, son Tom, mother Viola, and brother Ben. Son Aaron is a freshman at Albion College in Michigan and was unable to attend.

the Physicians Care Program and the Health Care Access Foundation has given him access to many of the present power brokers in state government who want to deal with health care. That should serve us very, very well. We've been able to make connections both in the executive branch and the legislative branch with physician leaders so that the legislators recognize their names, they recognize their honest desire for patient advocacy.

"More physicians are becoming involved in the political process and at the present time are willing to spend the time and effort to deal with legislative issues. But once the special session is completed, I doubt that many physicians will be overjoyed with the final health care reform package. The problem then will be how to keep those physicians involved. How do you make them understand that you can't win every battle, you can't accomplish every goal, and frequently you must go back to the legislature time after time. I'm convinced that if they create a reform package that doesn't deliver good patient care, *we will be able to amend it*. It probably will take years of legislative battle trying to undo those things they created that aren't right. But, I don't see us throwing up our hands and saying this was a terrible law, and therefore, we should quit.

"One of the very difficult jobs of

KMA leadership will be to convince physicians that they need to keep fighting and keep fighting until we get a type of health care and a delivery system and an insurance system that actually accomplishes what everyone wants it to — which is to make care affordable and accessible."

Future of KMA

Physicians are truly experiencing "Medical Challenges in an Age of Risk," there is an increasing number of complex issues, and an even greater need for all of medicine to speak with one voice. All physicians must join together to protect the rights of the profession, and Dr Monnig advocates the Kentucky Medical Association as the voice for those rights. "Government, especially, but also large insurers, want to dictate to physicians not only their fees, but how they take care of patients. They may be willing to negotiate with physicians, and if the Federal Trade Commission laws can be changed, I see the Kentucky Medical Association as the negotiating body. KMA is becoming more and more pertinent to the everyday lives of physicians and patients. It will continue to be a stronger and stronger organization."

As society and the medical profession change, and the diversity of practice modes makes unity by

physicians more important than ever, Dr Monnig is adamant about membership. "I would like to see the Kentucky Medical Association membership increase voluntarily. But if we reach the position where someone has to speak for the body of physicians in Kentucky, I'm not even opposed to looking at the possibility of making membership in the KMA mandatory for licensure."

Women in Medicine

Dr Monnig believes that only when the demographics of the entire profession are represented will the KMA be able to fully achieve its goals. He places such great importance on one particular area that prior to the health care reform special session, he had considered making "Women in Medicine" the focus of his leadership year. "Women are entering all areas of medical practice. They are becoming a diffuse group, their issues and concerns are the same as men in medicine, they do not need a separate category.

"There's tremendous opportunity for women in leadership positions at all levels of organized medicine. We should facilitate their involvement very, very rapidly so that we all are playing on the same team. We may need to do a better job of seeking them out and encouraging them to

join the leadership of organized medicine.

"KMA President-Elect Ardis Hoven has been a very active, good leader. She makes a great role model and will have a rapid progression through the leadership of the Kentucky Medical Association." Dr Monnig affirms, "The focus on women in medicine is going to happen whether I make it a primary goal or not."

The Profession

"It's a tremendous way to spend your life," asserts this advocate of medicine as a profession.

"No one can predict for those entering medicine today under what conditions they will be caring for patients. But if they enjoy taking care of people, there is no better way than by being a physician." Ever the optimist, he continues, "I'm also convinced that whatever we have today is transient. If you don't like managed care, if you don't like government involvement in health care, just look at the history of physicians. Physicians have survived almost every civilization, and we will always be needed."

Continually encouraging students and youngsters to enter what he considers the most noble profession, Dr Monnig stresses serving others and guarding assiduously against being self-serving. "If you're thinking of entering medicine for economic wellbeing, you may have a rude awakening. It will be very difficult, at least in the short term, to maintain the physician's economic status as it has been for the past 10 years. But this does not seem to be the main issue with most of the medical students I talk with. They want a better quality of life, which I have a hard time swallowing. When you become a physician, you can't become a 'part-time taker-carer' of people. You may be able to set aside some of the time in your life to not be touched by other people's problems, but if you want that as a major part of life, you

probably should not go into medicine. Most of your life is somehow going to be interrupted by the needs of people. But, it is just a *great feeling* to know that people need you, and then when you provide the service, they feel better. If people go into medicine with that attitude, there will always be a place for them."

Family and Interests

Dr Monnig is dedicated to his family. His pleasure is obvious as he speaks of them. "Donna and I met in college and were married between my sophomore and junior years of medical school. She had majored in English and was teaching. After our marriage, we managed an apartment building, she taught, and I moonlighted. We each earned \$5,000, and we thought we were rich. When I did my internship at the University of Illinois in Chicago, I signed a contract for \$5,000, but they gave me a \$5,000 raise because Cook County residents went on strike. When I got my raise, Donna went back to earn her master's degree in library science. She has been head of the Literature Department of the Cincinnati Public Library for several years.

"Donna and I celebrated our 25th wedding anniversary on July 8th. We have two sons. Aaron, 18, is a freshman at Albion College in Michigan, and Tom, 14, is a freshman in high school."

To keep fit, Dr Monnig is up at 5:15 each morning and walks for an hour before starting work at 7 am. He also swims about a mile four times a week. Since it's difficult for him to say no to commitments, he has little "free time" for relaxation. "I enjoy outdoor activities such as hiking, and spectator sports, especially football, baseball, and basketball. Most of the time, though, I spend going to meetings. In addition to my activities with the Kentucky Medical Association, I'm on the board of a nursing home and the Northern Kentucky Mental Health Association."

The Presidency

"If people realize at the end of my year that I worked for their best interest in these difficult times and that I gave my best effort to make sure that we protect patient advocacy and the rights of physicians to practice medicine, I'll be happy. I don't expect great things. We are in a time when we're going to have to live with compromises. I want people to know at the end of this year that I have fought the best battle that I could for their interests. And I don't plan on making this the end of my participation in medicine. I have lots of ideas even within my own practice about how I would like to improve efficiency in my office and the quality of care I give my patients.

"It would be nice to be remembered as someone who, first of all, was able to listen to the physicians' concerns. To be remembered as a person who not only tolerated controversy but invited the physicians to express their differing viewpoints. That through my efforts we were able to come together to create a policy or accomplish an objective — even when everyone came to the table with a different viewpoint — by working together realizing that our goal was to deliver good health care. So I want to be remembered as a leader, but a leader who was also a facilitator.

"At the end of this year, I hope that all outside parties will understand that the Kentucky Medical Association isn't going to roll over and die, that we *are here forever*. And, if they want health care reform, we'll help them get health care reform, but the organization is not going to lose its relevance. We are going to be the leaders in health care."

Association members will be well served by the presidency of William B. Monnig, MD.

—Sue Tharp
Managing Editor

Foundations

The 1990s promise ominous changes in the way medical care is delivered and the manner in which it is controlled. In the 80s we saw the intervention of entrepreneurs between our patients and the care they received. "As we speak" we witness the transformation of healing art into a business managed and dominated by government laws and regulations. Not since the mid to late 60s have we seen such a clamor for government control. Minnesota and Vermont have already adopted many changes, and Kentucky politicians promise that Kentucky will be on the "cutting edge" of reform. A major cause for outside intervention is the apathy that has slowly engulfed and divided our profession. Petty quarrels between specialty groups over reimbursement, referrals, authority, etc, have impaired our standing with the public. At a time when there is tremendous unemployment and those who are working are paid less, the last thing people want to hear is bellyaching among doctors.

The only possibility for survival is to unite. We can meet the challenges before us with a positive attitude and alternative solutions to problems. Yet, how can we do this unless we eradicate the malignancy of apathy? Are we so busy or so uncaring that we just sit back as spectators and watch our profession get decimated? Are we so secure, or so insecure, that we permit politicians, insurance companies, and other non-health care entities to tell us how to practice medicine? Isn't it about time that we assume an assertive role in our futures and the future of medicine? How do we as individuals achieve this goal? What can one person do to make a difference? The simple answer is *involvement!*

First, take an active role in your county medical society as well as the KMA and AMA. Second, know your local, state, and national legislators and don't hesitate to contact them. Communication is the key. The single most effective method of assuring access to a politician is to get involved in their campaigns — then, get out and VOTE! Your vote does make a difference. Last, each individual should unite with fellow physicians to form an organized body — a body that's cohesive, progressive, and assertive as it promotes the objectives of members. Did you know that we actually have such an organization?

AMPAC/KEMPAC was developed through the auspices of AMA/KMA in the mid 60s. It was a forerunner in the political arena and many associations later adopted or copied this model. But how effective is KEMPAC? It's only as effective as its members. There is indeed strength in numbers. Unfortunately, it seems that most physicians don't take politics seriously, which is demonstrated by the low participation in KEMPAC.

Out of 7,800 physicians in Kentucky, only 685 are members of AMPAC/KEMPAC. This roughly translates to 8%. Tell me how 8% of physicians can effectively represent the remaining 92%??? *They can't!* Why should a few politically active physicians support and represent the apathetic? *They shouldn't!* HOWEVER, DESPITE THE APATHY, KEMPAC CONTINUES TO BE THE DRIVING POLITICAL FORCE FOR ORGANIZED MEDICINE IN KENTUCKY!

Isn't it interesting that political changes brought about by so few can affect so many? Just think of the success KEMPAC has with only 8% participation. Think of the goals that

could be reached if membership grew to 20% or 50% or even 90%? The sky would be the limit! There is absolutely no reason I know for any physician not to join KEMPAC. It certainly isn't the cost of dues, which is only \$100 and \$100 for your spouse. Who can't afford \$100? Even though it's a small contribution, look at the impact we could have. In today's climate, the election and political process dictates (like it or not) that campaign contributions "wag the dog." Medicine didn't invent nor support this system . . . but times and events dictated that we either played by the rules or lost our autonomy. Contributing to candidates who share our political philosophies allows our profession to pursue progressive changes and effectively promote the welfare of our patients and the ideas of Kentucky physicians.

An old physician by the name of Martin Lipp, MD, once said, "The foundation of good medical care . . . is giving a damn." Now is the time to change your paradigm. Become active and let your voice be heard. Join KEMPAC now so that we can continue to represent all Kentucky physicians. Don't complain that no one cares about you as an individual physician. JOIN KEMPAC and get that positive feeling that you're doing something that may make a difference.

Only through unification can KEMPAC continue to represent medicine in Kentucky. KEMPAC needs and must have your support. We are blessed to be a part of the best fraternity in the world. Let's continue that tradition.

Samuel J. King, MD
Chairman, Board of Directors
KEMPAC

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Mammography

TO THE EDITOR: The editorial by Jannice O. Aaron, MD, on the value of mammography in the detection and the treatment of breast disease was very well done. I have one quibble.

When she finds a lesion on the initial mammogram which she interprets as cancer, she has no idea how long the lesion has been present or how fast it is growing. Therefore, I respectfully suggest she measure it accurately and include those measurements in her report.

The cancer may be small; she doesn't know if it is early until the patient has had thorough staging. Best wishes.

William T. Ramage, Jr, MD, FACS

Meeting the Needs of the 21st Century — Through Programs of Awareness and Education

TO THE EDITOR: What is "Project 100,000"? The reason for this project is to help identify those 100,000 people who have diabetes and are unaware of it at the present time in the state of Kentucky. Of the 12 million or more Americans with diabetes mellitus, an estimated 200,000 or so people with the disease live in the Commonwealth of Kentucky. Fifty percent or approximately 100,000 of these people have diabetes and are not aware of it at the present time in the state of Kentucky. The American Diabetes Association founded in 1920 and the new organization accepting the laity since 1969 have aimed at evaluating, diagnosing, and caring for all individuals with diabetes. The end-point of the ADA agenda was that the

quality of lives of the persons with diabetes may improve despite the increasing odds of target-organ damages. To reach a wider population and to promulgate the mission of the ADA, the affiliate chapters have set up various contact programs. In 1990, a program was launched here in Kentucky with emphasis which has gained regional recognition and is now being implemented at a national level by other affiliates of the National American Diabetes Association. The first implementation of this project occurred back in November 1990, in the Lyles Mall in Louisville, KY. A screening program occurred where people were tested for blood glucose levels and, if found elevated, were referred to a medical physician for follow-up. One hundred and eighty-one people were tested and six people were referred for further medical evaluation.

Also present at this event were information resources and examples of diabetic foods, exercise regimens, and general counseling.

RISK: In November 1990, the African-American community in Louisville was a target audience for the initial prototype of this program in a mall located in the population center. The risk of diabetes mellitus has been known to be higher in the African-American people, so there was need for intensive awareness of this disease in the afrcoids of the Commonwealth of Kentucky. ADA — Kentucky Affiliate, Inc, emphasized this point, "... it is estimated that 100,000 Kentuckians do not know they have diabetes. The rate among African-Americans is 30-40% higher than the rest of the population. ... " The etiology of genetics, diet, and inadequate health care contributed to the illness.

DAMAGE: For individuals with diabetes who have lower than usual morbidity and/or mortality, the disease must be diagnosed early to prevent often irreversible target-organ

destruction. Since it was thought that many of the African-Americans have not been diagnosed with diabetes mellitus, they must be reached before they are presented with complications such as blindness, stroke, coronary artery disease, renal failure leading to dialysis, vascular occlusion treated by amputations, and mortal opportunistic infections. In these days of cost control in healthcare delivery, the undiagnosed children, men, and women with diabetes mellitus must be identified early to save their lives and avoid preventable health expense on disease complications.

GOAL: Our goal is to outreach into all areas of Kentucky providing education and testing for the general population. In an effort to reach the undiagnosed population, we have developed a process utilizing a coalition of physicians, hospitals, community leaders and corporations.

We have in place an organization focused on this process. One of the elements for the success of this program is framed around six locations throughout Kentucky. Each of these important locations are headed by one key person.

<u>CITY</u>	<u>KEY PERSON</u>
Louisville	Ed Causey 502/896-5099
Owensboro	Mary Linda Rogers 502/686-7747
Lexington	Chris Carter 606/254-1146
Bowling Green	Michelle Buffum 502/782-5171
Ashland	Condit Steil 606/325-1483
Hazard	Jonathan Mays 606/439-3557

NEXT STEPS — JEFFERSON COUNTY: This testing program, to be held during Diabetes Month in November 1992, includes diabetic screening, physician and hospital participation. The Project 100,000 Guide was compiled and edited by coordinators Roy Keith, Don Combs, Frederick Davis, Allan Weiss, Robert

Maddox, Dr O'Tayo Lalude, Doug Dressman, Beth Schofield, Jim Williams, Jack Toll, Brenda Sweatt, Linda Wheeler, Dr Russell Hoffman, Lawrence Smith, Beth Hendricks and Lisa McCrea. The ADA would like to offer you the opportunity to help your local community. To volunteer your time and expertise would help all the diabetics in the state. Please contact the key person (listed above) in your area for more specific information on how you can participate.

Norman D. Radtke, MD
Project 100,000 Chairman

Pseudo Pericardial Rub

TO THE EDITOR: We would like to report a phenomenon which we have termed "pseudo pericardial rub."

Patient 1. An 84-year-old white male with a history of alcohol abuse, coronary artery disease, diabetes mellitus, and chronic renal insufficiency was admitted to the hospital for an evaluation of increasing abdominal girth. His vital signs were: pulse 62/min, respiratory rate 20/min, blood pressure 174/82 mm/Hg, temperature 37°C. On examination he was cachectic. Bibasilar pulmonary crackles were heard. Ascites was present. The heart sounds were normal. However, a scratchy sound timed with diastole was heard over the precordium using the diaphragm of the stethoscope. A 2-D echocardiogram was normal.

Patient 2. A 60-year-old white male was admitted to the hospital for exacerbation of chronic obstructive lung disease. On examination he was noted to be moderately dyspneic. The

vital signs were: pulse 90/min, respiratory rate 24/min, blood pressure 110/80 mm/Hg, temperature 37°C. Bilateral respiratory wheezes were heard. The heart sounds were distant. A rubbing sound was heard with the diaphragm of the stethoscope over the precordium during the diastolic phase of the cardiac cycle.

Both of these patients had normal renal function and no clinical evidence of disease known to be associated with pleuritis or pericarditis, such as viral infection, myocardial infarction, or pulmonary embolism. Both were examined and the findings recorded by a junior medical student and a first year internal medicine resident. When the patients were re-examined by a renal fellow and attending physician, it was noted that the rubbing sound was absent when the bell of the stethoscope was employed. Furthermore, the adventitial sound was heard only during the diastolic phase of the cardiac cycle in the region of the apex, did not increase in the sitting position, and was persistent and unchanged in character over several days.

Pericardial rub is generally described as a high-pitched, to-and-fro rubbing, scratching, or grating sound heard over the precordium and is associated with inflammation of the pericardium.^{1,4} It usually increases when the patient is sitting upright or leaning forward, and the sound is frequently inconsistent.² The rub may have three components, each associated with a cardiac movement, ie: atrial systole, ventricular systole, and diastole. Not infrequently, only two components or even one component are heard.⁵ However, pericardial rub heard during diastole is distinctly unusual. In a series of 100 patients with pericardial rub reported by Spodick,⁵ none had isolated diastolic rubs. However, an isolated

diastolic rub may occur, and in such cases may be confused with the murmur of aortic insufficiency. Disappearance or changing character over a period of days is needed for proper diagnosis.⁶

In our patients, we believe that the rubbing sound resulted from friction of the skin against the diaphragm of the stethoscope during cardiac contraction. We suggest that the diagnosis of "pseudorub" be considered in thin or cachectic patients (in whom the cardiac impulse is often prominent) with persistent precordial rubbing sounds heard only in diastole.

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The Prostate Book Sound Advice on Symptoms and Treatment

Stephen N. Rous, MD

W. W. Norton & Company, Inc
500 Fifth Avenue
New York, NY 10111

This is the updated version of Dr Rous's original book of 4 years ago. His final chapter, called "Bringing This Book Up to Date," is really an addendum. Prostate specific antigen, prostate ultrasound, new information on benign prostatic hyperplasia, and cancer diagnosis and treatment are discussed in depth. The first 224 pages are really the original version, but are quite up to date and readable. This book is meant for the lay person, having to learn about prostate problems. Written in familiar language and dotted with diagrams and pictures, the reader can browse and concentrate at will. In fact, Dr Rous's background in academic urology (several professorships at leading university programs) belies his ability to pepper his didactic

information style with practical and sometimes very common terminology.

Initially the anatomy of the prostate and surrounding region is discussed. The following chapter takes the patient through a simple diagnostic workup, with minimal details of examination technique, laboratory data, and the formation of an opinion. The three main categories of illness — infection and inflammation, benign prostatic hyperplasia, and prostatic cancer — are each granted equal space and emphasis. I found the chapter, "What You (the Patient) Can Anticipate at Each Step Along the Way," to be very succinct and compassionate for the scared and concerned patient and family. Family members are expected to be involved with this process and

several parts of the book are directed at others involved with the patient.

Therapeutic options for prostatic conditions and diseases are granted almost half the book. Most patients can only stomach just so much information on diagnosis, before they are anxious to discover what can be done. Medical, surgical, and radiation therapies are detailed, again in digestible language.

A closing glossary and index are useful tools for the reader, especially when first confronted with a lot of alien information. This book is a good one to recommend, for its information and its importance.

Stephen Z. Smith, MD
Book Review Editor

Board of Trustees August Meeting



President S. Randolph Scheen, MD, presented a bound volume of Journals to Immediate Past President Preston P. Nunnelley, MD.

The KMA Board of Trustees held its fourth meeting of the Association year on August 5-6, 1992, at the Hyatt Regency Hotel in Louisville. Reports were given by the President; Secretary-Treasurer; President, Auxiliary to KMA; Senior Delegate to AMA; and Chairman, Committee on State Legislative Activities. In addition, The Board heard presentations from representatives of the Kentucky Medical Insurance Company, the Board of Medical Licensure, the Director of the Medicare Part B Program in Kentucky, and the Chairman of the KMA CME Committee.

President Scheen presented a bound set of *Journals* to Immediate Past President Preston P. Nunnelley, MD, which were published during his term as President. It was reported to the Board that Hospice of Louisville, Inc, had elected to pay off its note to KMA for the sale of the headquarters building on Ephraim McDowell Drive, and the entire amount had been invested in a building fund for a



Board Chairman Russell L. Travis, MD, Lexington, studied the agenda.



future home for the Association.

The Secretary of the Cabinet for Human Resources, Leonard Heller, PhD, attended the Board meeting to report on activities relating to health care reform, which was followed by a question and answer session. The Board members spent the remainder of the Wednesday evening session discussing the health care reform issue. Plans were discussed to hold a forum on this subject at the first meeting of the KMA House of Delegates on September 14, 1992, which would include Secretary Heller, a state Legislator, and a KMA officer.

The Board reviewed its Ad Hoc Committee reports, as well as each final committee report to be submitted to the 1992 House of Delegates. Several Resolutions were authorized for submission to the House. A listing of actions taken to implement the directives of the 1991 House of Delegates was distributed, and it was noted that the same information would be sent to every Delegate as an addendum to the 1992

Board Chairman's Report. It was agreed to invite Alternate Trustees to attend the first meeting of the Board to be held during the Annual Meeting on Sunday, September 14.

The Board members expressed support for a letter of intent signed by the Kentucky Medical Insurance Company to form a holding company with the Physicians Insurance Companies of Ohio and Indiana, and endorsed the idea of a joint meeting of the KMA and KMIC Boards.

In other action, the Board authorized a \$10 voluntary assessment for the Legal Trust Fund to be included with the 1993 dues billing; appointed Albert H. Joslin, MD, Owensboro, to the KEMPAC Board of Directors; and concurred with the nomination of KMA Alternate Trustees to serve on a Medicare Physicians Advisory Committee.

The next meeting of the Board was scheduled for Sunday, September 14, 1992. *KMA*



Top to bottom: President-Elect William B. Monnig, MD; Secretary-Treasurer William P. VonderHaar, MD; AKMA President Beryl Dodds; Secretary of the Cabinet for Human Resources Leonard Heller, PhD.



Members of the KMA Board of Trustees are pictured above and in photo on facing page.

PEOPLE



C. William Schmidt was recognized at the KMA August Board meeting for 20 years of dedicated service as Executive Director of the Kentucky Board of Medical Licensure, Louisville. Under his leadership, the Licensure Board has achieved ranking among the top five Boards in the nation.

Schmidt joined the KMA staff as an Executive Assistant in March of 1971 and the following year accepted the challenge to manage the Board of Medical Licensure.

Donald R. Kmetz, MD, dean of the U of L School of Medicine and vice president for hospital affairs, has been named acting vice president for health affairs, effective September 1.

In his new position, Dr Kmetz will report directly to the university president and be responsible for promoting new levels of cooperation among U of L's health sciences schools. The deans of the Schools of Medicine, Dentistry and Nursing, and the College of Health and Social Services will report to him. All current duties of the vice president for hospital affairs will be incorporated in the new position.

Dr Kmetz will retain the medical

school deanship while serving as acting vice president to ensure continuity in organization, accreditation, and recruiting.

The Oldham County Board of Health recently dedicated its new board room to the late **Dr Edward G. Houchin**, who died June 14.

Dr Houchin served as chairman of the board from 1965 until 1979, and as a member of the board until his resignation for health reasons shortly before his death.

John S. Spratt, MD, a surgical oncologist, was an invited speaker on breast cancer at the symposium on medical malpractice recently sponsored by the Law Journal Seminars Press in New York. He also presented "The Risky Shift, Fallacies in Consensus Decisions" at a meeting of the Association for Health Services Research held in Chicago in June.

Several KMA members recently received 3-year appointments as Cancer Liaison Physicians for the Hospital Cancer Program in their area. They are **Steven W. Smith, MD**, Greenview Hospital, Bowling Green; **Hossein Fallahzadeh, MD**, Humana Hospital-Lake Cumberland, Somerset; and **I. N. Nayak, MD**, ARH Regional Medical Center, Hazard.

 UPDATES

Arthritis Foundation

The Arthritis Foundation, Kentucky Chapter placed first in the category of Professional Education for 1992 Arthritis Foundation programs. Seventy-one chapters of the Arthritis Foundation nationally compete annually for these awards. **Ronald J. Fadel, MD**, is Board Chairman of the Arthritis Foundation, Kentucky Chapter.

Hospital Receives KODA Award

The UK Hospital was the recipient of the Julie McGee Lambreth Award, presented annually to the donor hospital whose program demonstrates a strong, long-term commitment to increasing donor and tissue donation. The award was presented during the Kentucky Organ Donor Affiliate's annual advisory board dinner.

UK Hospital was chosen because of the past year's efforts by the UK Donation Strategy Team to thoroughly analyze and improve the donation process. As a result, UK Hospital tripled its number of organ donors from 1990 to 1991. In 1990, six families gave consent for organ donation. In 1991, 19 families chose the option of donor donation.

RBRVS Updates Recommended

The US Department of Health and Human Services (HHS) has issued recommendations for Medicare physician payment schedule conversion factor updates for 1993. Recommendations include a two-part update that will be applied on a service-specific basis: for surgical services, a 2.6% update, and for nonsurgical services, a 0.3% update. This recommendation is based on an update equal to the projected Medicare Economic Index (MEI) of 2.2%, plus or minus the percentage points by which the Medicare Volume Performance Standard (MVPS) was exceeded or was less than the actual rate of increase for surgical and nonsurgical services for the Fiscal Year 1991.

HHS recommended MVPS figures for setting the 1994 default conversion factor update. Those include 6% for surgical services and 7.9% for nonsurgical services.

In addition, recommendations were made for possible modifications to be made in 1994:

1. A single MVPS and conversion

factor update.

2. Acceleration of the payment schedule transition.
3. A separate MVPS for primary care services.
4. A restructuring of graduate medical education payment to favor primary care and nonhospital based, ambulatory residency training sites.
5. Increased emphasis on primary care in Public Health Services programs.

The AMA has argued that multiple conversion factor updates are inconsistent with the RBRVS and should not have been recommended. The AMA still believes that important elements of the RBRVS require correction and refinement.

Change in Medicaid Genetic Substitute Law

KMA has been informed that the Kentucky Medical Assistance Program (Medicaid) is in the process of notifying all providers that it will no longer accept the words, "Do not Substitute," on prescriptions when physicians are directing the pharmacist to not use a generic substitute. According to Medicaid, the Omnibus Budget Reconciliation Act of 1991 mandates that unless the words, "Brand Medically Necessary," are handwritten on the prescription, the Medicaid Program is not to reimburse the pharmacist for that drug. This wording may not be preprinted, stamped, or otherwise abbreviated on the prescription. This mandate is contrary to Kentucky Revised Statute 217.822, which allows physicians to indicate "Do Not Substitute" in the manner of their choice, except that the indication shall not be preprinted on a prescription. Therefore, the change will apply only to Medicaid recipients. Medicaid has advised it will provide additional written information to all physicians in the near future.

New Prenatal Test Available at UK

Through a new prenatal test now available at UK Hospital, many expectant mothers can learn earlier than before about the health of their unborn babies.

The test — chorionic villus sampling (CVS) — is an option to amniocentesis, the standard prenatal diagnostic test. But unlike amniocentesis, which is not done until the 13th week of pregnancy, CVS can be performed as early as 9 weeks.

"Another advantage to CVS is that we can get the results back faster — within 10 to 12 days," explains **Dr Berry A. Campbell**, UK department of obstetrics and gynecology.

In addition to detecting chromosomal disorders including Down's syndrome, CVS can also show whether a fetus has been spared genetic defects that often run in families such as sickle cell disease, cystic fibrosis, or hemophilia.

MRSA Infection Studied

To evaluate the growing concern with methicillin resistant *Staphylococcus aureus* infection (MRSA) patients, the KMA met with members of the Kentucky Association of Health Care Facilities and the Kentucky Hospital Association to explore the problem of MRSA patients remaining in hospitals for extended periods of time without being transferred to a nursing home. Extended stays for MRSA patients in hospitals are not only expensive, but also unnecessary.

It was discovered that there was a misunderstanding on MRSA infection. New treatments for MRSA infection enable patients to be safely transferred to nursing homes. In 1991, the Cabinet for Human Resources published "Guidelines for the Control of Methicillin-resistant *Staphylococcus aureus* Infections" to assist health care workers in proper treatment of the

infection.

The KMA urged the KHA and KAHCF to continue to educate its members on getting more MRSA patients out of hospitals and into nursing homes. To get a copy of the "Guidelines for Control of MRSA Infection," contact the Cabinet for Human Resources, Department for Health Services, 502/564-7243.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Calloway

Zebulon L. Bowman, MD — OPH
300 S 8th St #284W, Murray 42701
1977, Duke U

Franklin

Rice C. Leach, MD — PH
P O Box 1497, Frankfort 40602
1966, U of Kentucky

Jefferson

Norris D. Hill, MD — PD
1317 Oak Hill Rd, Louisville 40213
1985, U of Texas

William K. Hornung, MD — AN
803 Circle Hill Rd, Louisville 40207
1984, U of Kentucky

James D. Jackson, MD — IM
2503 Kings Hwy, Louisville 40205
1987, U of So Alabama

Jeffrey D. Johnson, DMD — DENT
501 S Preston St, Louisville 40202

Robert L. Slaton, EdD
UL Primary Care Ctr, Louisville 40292

Paul A. Southall, MD — PD
9822 Third St Rd #100
Louisville 40207

1988, U of Louisville

Peggy S. Stephens, MD — P
4010 Dupont Cir #227
Louisville 40207

1985, U of Kentucky

Elizabeth H. Wade, MD

L10 Audubon Med Pl
Louisville 40217
1974, U of Kentucky

— PD

Northern Kentucky
Christopher Cirulli, MD

20 Med Village Dr, #308
Edgewood 41017
1982, U of Kentucky

— U

Perry
Philip S. Backus, MD

P O Box 1587, Hazard 41701
1958, U of Pennsylvania

— P

Pulaski
Kevin T. Kavanagh, MD

402 Bogle St #3, Somerset 42501
1978, State U of New York, Buffalo

— OPH

Spencer
Thomas C. Crain, MD

112 Green Acres Dr
Taylorsville 40071
1982, U of Guadalajara

— FP

Taylor
Robert B. Romines, MD

105-B Greenbriar Dr
Campbellsville 42718
1987, U of Louisville

— S

Warren
Danny Harrison, MD

201 Park St, Bowling Green 42101
1983, U of Louisville

— S

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Jefferson

Betty W. Joyce, MD
Leo A. Schwendau, MD

— IM

— PD

Northern Kentucky

Karl M. Schmitt, MD

— FP

DEATHS
Robert T. Crosby, MD

Bowling Green
1940-1992

Robert T. Crosby, MD, an ophthalmologist, died in May. Dr Crosby was a 1965 graduate of Louisiana State University School of Medicine and was an active member of KMA.

Robert J. Salisbury, MD

Mount Sterling
1925-1992

Robert J. Salisbury, MD, a family practitioner, died July 16, 1992. Dr Salisbury graduated from the University of Louisville School of Medicine in 1953 and was a life member of KMA.

Charles F. Sowards, DO

Pikeville
1928-1992

Charles F. Sowards, DO, a general practitioner, died August 9, 1992. Dr Sowards graduated from Kansas City College of Osteopathy and Surgery in 1967 and was an associate member of KMA.

Help for Impaired Physicians

Through its Committee on Impaired Physicians, KMA helps doctors who are suffering from alcoholism and drug addiction. The thrust of the program is rehabilitative, not punitive. The Committee is composed of physicians who have special expertise in these areas, some from personal experience. Effective treatment for these illnesses is achieved most easily when the disease is detected early; family, friends, and associates are urged to avoid misguided sympathy which enables the condition to deteriorate.

HELP US TO HELP

Call the KMA Impaired Physicians Program
(502)426-6200.

OCTOBER

25-30 — 23rd Family Medicine Review, Session III; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086; 606/233-5161.

29-31 — 42nd Annual Obesity & Associated Conditions Symposium, sponsored by the American Society of Bariatric Physicians, The Westin Hotel, Chicago. Contact: ASBP, 5600 S Quebec St, Ste 160-D, Englewood, CO 80111; 303/779-4833, FAX 303/779-4834.

30-31 — 26th Annual Newborn Symposium, The Seelbach, 500 Fourth Ave, Louisville, KY. Contact: Lynette McInnis, University of Louisville, Department of Pediatrics; 502/588-5329.

NOVEMBER

8-12 — 96th Annual Meeting of The American Academy of Ophthalmology; Dallas Convention Center. Contact: The American Academy of Ophthalmology, Meetings Dept, PO Box 7424, San Francisco, CA 94120-7424; 415/561-8500.

12-15 — Southern Medical Association's 86th Annual Scientific Assembly; San Antonio, TX. Contact: SMA's Member Ser-

vices Center; 800/423-4992; or 205/945-1840.

27-December 4 — 78th Scientific Assembly and Annual Meeting of the Radiological Society of North America (RSNA), McCormick Place, Chicago. Contact: RSNA, 2021 Spring Road, Ste 600, Oak Brook, IL 60521, 708/571-2670; FAX 708/571-7837.

1993**FEBRUARY**

7-11 — Southeastern Surgical Congress Annual Meeting; Tarpon Springs, FL. Contact: Southeastern Surgical Congress, 1776 Peachtree St, NW, Suite 4010N, Atlanta, GA 30309; 404/607-8958.

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AMA Backs Regulatory Relief, Anti-Hassle Legislation

The American Medical Association continues to lobby for Medicare physician regulatory relief amendments introduced in the House as HR 2695 and in the Senate as S1332, to cutback on Medicare hassles. In short, legislation addresses:

- **Medicare Secondary Payor:** prohibits payment denials for necessary covered services if the patient fails to complete questionnaires.
- **Extrapolation:** gives physicians the option of requiring carriers to produce evidence of a pattern of payment error.
- **Carrier User Fees:** prohibits charging for paper claims, filing errors, unsuccessful appeals, applications for unique provider numbers and medical review requirements.
- **Annual Carrier Evaluations:** requires state medical society input on evaluation standards and requires this to be included in annual carrier performance evaluations.
- **Medicare Carrier Accountability:** allows administrative appeals when the carrier improperly implemented Medicare policy.
- **Physician Peer Review:** requires all Medicare medical necessity denials be reviewed by identified, appropriately licensed physicians of the same specialty.

All provisions were included in a separate package of Medicare amendments approved by the House Energy and Commerce Committee. The AMA will continue to work to advance this legislation prior to adjournment.

AMA Recommends Medicare RBRVS Updates

The 26-member American Medical Association Specialty Society Update Committee, or RUC, presented its first recommendations to HCFA. These address relative values for 253 new or revised CPT codes and are intended to

help HCFA as it develops the 1993 Medicare fee schedule. The AMA views RUC's update activities as central to implementation and maintenance of the RBRVS.

RATES AND DATA

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Survival of Persons
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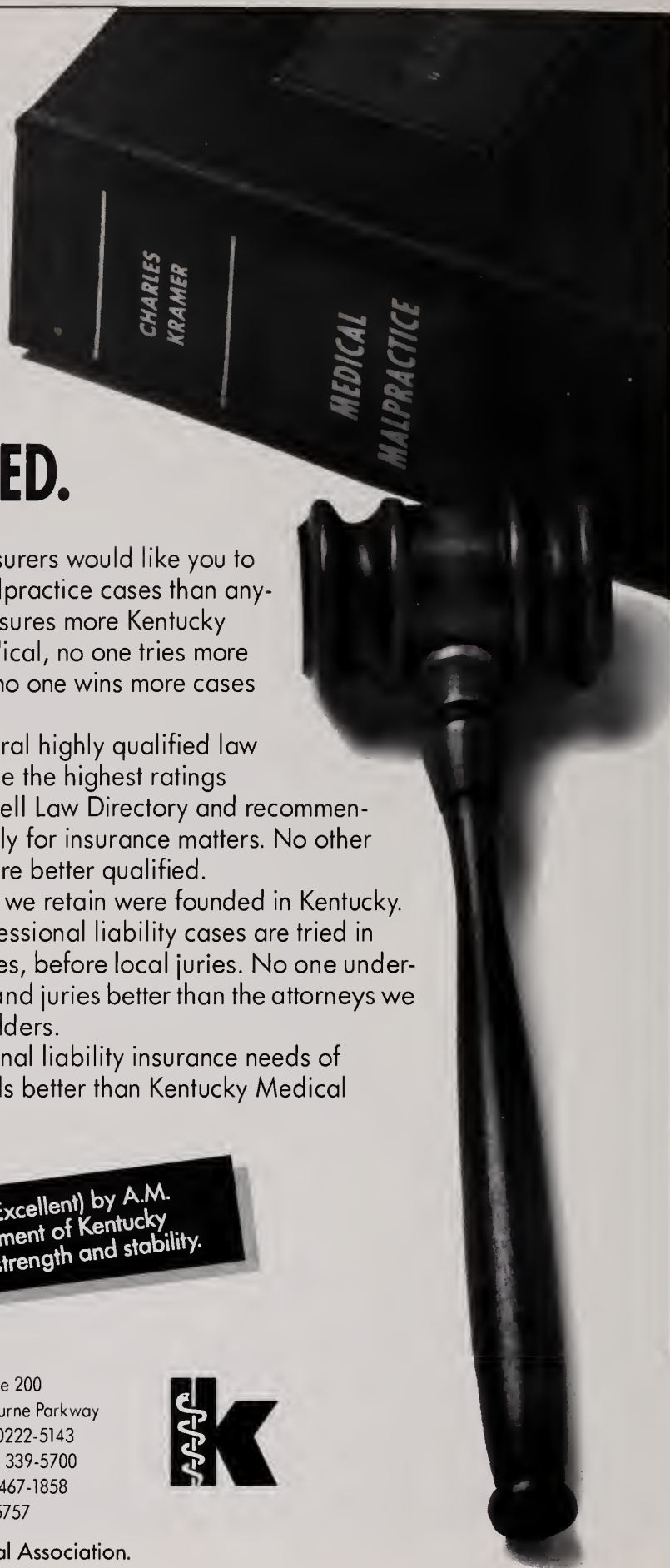
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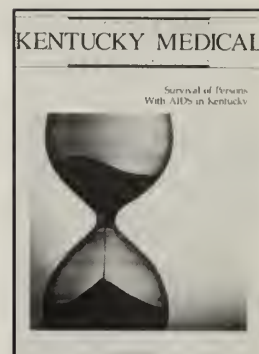


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COVER: Illustration by Lee Wade of Louisville. The symbology of this illustration as explained by Mr Wade— "The sunrise symbolizes that our knowledge of AIDS and its treatment is still in the early stages, while the hourglass is symbolic that time is running out for those currently infected with the disease."

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William B. Monnig, MD

Leadership — The President's Concept

Health care reform will dominate the activities of the Kentucky Medical Association for the remainder of my term in office. The House of Delegates has reaffirmed the authority of our elected leaders to negotiate solutions to health care reform issues. Those solutions will attempt to address the health care needs of our patients. But our solutions will also maintain the professional status of physicians.

You have empowered me to act in those best interests; but what kind of leadership can you expect?

I have been fortunate to participate in Leadership Kentucky sponsored by the Kentucky Chamber of Commerce. Through that organization, I had the opportunity to formally and informally network with non-physicians throughout the state. My perspective of the state's needs and ability to cope has been broadened by that experience. My exposure to seasoned, crusty leaders and youthful, budding leaders across the state has given me a perspective that is hard to achieve as we progress through the levels of leadership of organized medicine. The "guideline" to achieve leadership status in the KMA is well known, and the

"outcome" is equally well known — being the President and/or the Chairman of the Board or being disappointed at not achieving those goals.

The traditional path to leadership status has served us well, and I do not want to demean it. But I believe that we need to create an atmosphere of acceptance of alternate expressions of leadership. We not only need to be tolerant of other people's leadership initiatives; but we must wholeheartedly embrace their efforts, recognize their potential, and encourage their development for the good of organized medicine.

My ideas of leadership have been formalized through interaction with George Manning, Professor of Psychology at Northern Kentucky University, who I initially met through Leadership Kentucky. Much of the remainder of this article was garnered from a series of books and tapes that he coauthored with Kent Curtis, Professor of Industrial Technology and Education, Northern Kentucky University.

Leadership is defined as (1) showing the way or directing the course of action; (2) influencing

or causing to follow by words and deeds; (3) guiding the behavior of others through ideas, strength, or heroic feats; (4) the position or function of one who leads; and (5) the ability to lead.

Eugene E. Jennings stated, "Leadership means leaving a mark. It is initiating and guiding, and the result is change. The product is a new character or direction that otherwise would never be. By ideas and deeds, leaders show the way and influence the behavior of others."

Health care reform in Kentucky needs the leadership ability of many people. We need the leader who is devoted to great causes and noble works. The Governor has chosen that role for himself, and there is no need to challenge his designated role. The legislators are gradually exerting their leadership role as rulers. They will create the law; they will exercise their individual and collective power to dictate the legal framework for health care reform. You might wonder what leadership role is left for physicians who are so intimately related to health care and who will so greatly be effected by its reform. We should, and will, take the lead as teachers, as value creators, and if need be, rule breakers. Those are leadership roles that we are especially equipped for. They are leadership roles that we can exert within the formal framework of state reform and also in an informal network that will influence not only those with noble causes, but also those who would exert their power to obtain their ends. If rules and regulations are promulgated that interfere with good health care, those rules and regulations must be bent and even broken to deliver good patient care. We also must be willing to challenge the laws and lawmakers to assure their effect improved patient care and improved patient care access.

Eugene E. Jennings formulated a question that needs to be considered about leadership. "Is leadership the

product of nature or nurture? Which is more important, the individual or the environment?" Historically, leadership has been attributed to the individual. Eugene E. Jennings has also stated, "Throughout history, people have believed that certain individuals possess special qualifications allowing them to rise above the masses, to assume responsibility, to exert power, and to become leaders."

More recently, leadership has been viewed as an acquired competency, the product of many forces, not the least of which is circumstance. In this sense, leadership is seen as a social phenomenon, not a personal trait. Hopefully the KMA leadership possess special qualifications, but let me assure you that our leadership position and potential has been greatly influenced by the product of many forces, not the least of which is circumstance. Who would have thought that Kentucky would be thrust to the forefront of health care reform this year?

Ralph M. Stogdill, one of the most distinguished scholars on leadership, has found certain traits of the individual that correlate with leadership. Stogdill writes:

The leader is characterized by: a strong drive for responsibility and task competitions; vigor and persistence in pursuit of goals; venturesomeness and originality in problem solving; drive to exercise initiative in social situations; self-confidence and sense of personal identity; willingness to accept consequences of decision and actions; readiness to absorb interpersonal stress, willingness to tolerate frustration and delay; ability to influence other persons' behavior; and capacity to structure social interactions systems to the purpose at hand.

It can be concluded that the cluster of characteristics listed above differentiate leaders from followers,

effective from ineffective leaders, and higher echelon from lower echelon leaders.

Harry Levinson has said, "Evidence shows that both nature — qualities of the person — and nurture — environmental factors — are important elements in the leadership equation. Leadership results from the inextricable interactions between the two." The present "leadership" of the KMA is certainly an excellent example of this interaction.

What are the motives for leadership?

There are three basic motives for leadership: (1) power — the desire to have influence, give orders, and have them carried out; (2) achievement — the need to create and build something of value; and (3) altruism — a heartfelt interest in helping others.

Some, like Winston Churchill, need to influence the course of events; others, like Madam Curie, need to achieve, to make changes; and yet others, like Albert Schweitzer, need to serve. Hopefully achievement and altruism will motivate the KMA leadership.

George Manning said, "The golden key to leadership is character. Some people are able to inspire others and bring forth loyalty. A person who has such a personality is said to have character. In our society, such words as honor, integrity, and courage are used to define character. These are desirable characteristics that merit the respect and confidence of others."

Psychologist David McClelland describes the influence of the golden key — leadership by character.

We set out to find exactly, by experiment, what kinds of thoughts the members of an audience had when exposed to a charismatic leader. They were apparently strengthened and uplifted by the experience; they felt more powerful, rather than less powerful or

submissive. This suggests that the traditional way of explaining the influence of leaders on followers has not been entirely correct. The leader does not force followers to submit and go along by the sheer overwhelming magic of personality and persuasive powers. In fact, the leader is influential by strengthening and inspiring the audience. The leader arouses confidence in followers, and the followers feel better able to accomplish whatever goals they share with the leader.

My full intent is to lead the KMA in this fashion.

Management consultant Fred Fiedler writes, "Leadership is the use of power and influence in order to accomplish a task." The art of

persuasion is an important key to leadership. This art requires ability in four important areas. *Understanding:* Leaders must understand why people do what they do. *Sensitivity:* The ability to see things from the other person's view and "walk a mile in the other person's shoes" is an important element of persuasion. *Listening:* Leadership requires interest in others and the ability to listen effectively. *Speaking:* Vocabulary, clarity, and eloquence are needed to persuade others to take action. Hopefully as the year progresses, the KMA members will see our leadership demonstrate these important persuasive qualities. You have chosen an imperfect President at this propitious time. But I believe we are up to the challenge. You now know my framework and

parameters for leadership.

There is an open invitation to every member of the KMA to exert his or her own influence on the decision making process of your leaders. We, the leaders of the KMA, appreciate the confidence of the membership in our ability, but we also recognize the effectiveness of the informal leadership that motivated physicians, spouses, and friends can have in creating meaningful health care reform consistent with KMA principles.

I would like to thank George Manning for his influence on this article.

William B. Monnig, MD
KMA President

Survival of Persons with AIDS in Kentucky

Margaret Stapleton, MSPH; Karen Adams, RN, BSN; Reginald Finger, MD



Of all reported Kentucky adult/adolescent cases of AIDS (124) with diagnosis dates from July 1, 1990, through June 30, 1991, 33% died within three months of diagnosis. To discern possible reasons for these very short survival times, information was analyzed from the CDC AIDS Confidential Case Report of the 124 patients and from the hospital charts of the 29 patients who were reported as having died within the month of or the month following diagnosis. Data suggested that survival for three months appears to be less likely for blacks, for males, and for those 30 through 34 years old. In the cohort the first diagnosis of AIDS was made at 40 different hospitals and the patients presented to 77 different physicians. Of chart-reviewed patients, 16 of the 29 (55.1%) were previously known to be HIV-positive. The most commonly identified likely reason for short survival time from AIDS diagnosis to death was that the diagnosis had been previously missed (10 of the 29 patients — 34%). The study showed that many known to be HIV-positive for some time had apparently received little or no care for their infection from testing until diagnosis with AIDS. Medical review of patient charts suggested that scatter of caregivers may have resulted in some errors in diagnosis and treatment decisions. Also, considerable numbers of persons with HIV infection are either not utilizing the existing HIV counseling, testing, and follow-up systems or are not receiving medical care for their infection once it is identified.

Introduction

Kentucky's first case of acquired immunodeficiency syndrome (AIDS) was reported in 1982.¹ From then through December 1991, 694 cases have been reported in Kentucky residents. The epidemiology of these cases has been reviewed in several issues of *Kentucky Epidemiologic Notes and Reports*.²

The incidence of AIDS cases in Kentucky from December 1990 through November 1991 was 4.7 cases per 100,000 population compared to the national average of 17.4 cases per 100,000 population. However, the cumulative case-fatality rate for all Kentucky cases is 72% compared to a rate for the nation of 65% published by CDC (Table 1).^{3,4} The median survival time for people reported with AIDS in Kentucky through 1991 was 10 months⁵ compared with approximately 20 months for the nation.⁶

As of January 1, 1992, 124 Kentucky adult/adolescent cases of AIDS with diagnosis dates from July 1, 1990, through June 30, 1991, had been reported. By January 1992, 56 (45%) were known to have died. Of these, 41 (73%) died within 3 months of diagnosis. An in-depth study was conducted to discern possible reasons for these very short survival times.

Methods

The study population consisted of all patients with AIDS, 13 years or older, reported to the Kentucky Department for Health Services, who were diagnosed with their first known disease indicative of AIDS from July 1, 1990, through June 30, 1991. This 1-year cohort, each member of which met the CDC clinical case definition of AIDS,⁷ was followed for a minimum of 6 months through December 1991.

Information for the study was obtained from the CDC AIDS Adult Confidential Case Report of the patient. Variables entered into *Epi Info* programs⁸ were: gender, race or ethnicity, age at diagnosis, exposure category, initial disease indicative of AIDS, date of diagnosis, date of death, diagnosing physician and hospital, and survival time following diagnosis. No personal identifiers were entered. Chi-square analysis was used to examine differences between patients dead and those alive in the variables of sex, race, age at diagnosis, exposure category, and disease indicative of AIDS.

AIDS Survival in Kentucky

Table 1. AIDS, Reported Cases and Case-Fatality Ratios by Year of Diagnosis, Kentucky and United States, 1981 through 1991.

Year of Diagnosis	KENTUCKY			UNITED STATES	
	Number of Cases	Number Now Deceased	Case-Fatality Ratio %	Number of Cases	Case-Fatality Ratio %
*1981-85	55	54	98%	21,922	91%
1986	39	37	95%	18,494	87%
1987	66	58	88%	27,558	83%
1988	118	105	89%	33,590	76%
1989	143	104	73%	38,154	64%
1990	151	85	56%	38,280	47%
1991	87	31	36%	28,394	24%
Total	659	474	72%	206,392	65%

*Kentucky's first case of AIDS was reported in 1982

Table 2. Characteristics of Reported Kentucky Adult AIDS Cases (Diagnosed July 1, 1990 through June 30, 1991) by Survival Status.

	Total 124 Cases	Alive	
		Number 68	Percent 55%
Sex			
Male	108	57	53%
Female	16	11	69%
Race/Ethnicity			
White	94	51	54%
Black	27	14	52%
Hispanic	3	3	100%
Age at Diagnosis			
<30	33	20	61%
30-34	29	14	48%
35-39	27	15	56%
≥40	35	19	54%
Exposure Category			
Men who have sex with men	84	46	55%
Injecting drug use	11	7	64%
Men who have sex with men and inject drugs	7	3	43%
Hemophilia/coagulation disorder	3	1	33%
Heterosexual contacts	10	5	50%
Receipt of blood transfusions or components	7	4	57%
Other	2	2	100%
AIDS Index Disease at Diagnosis			
<i>P. carinii</i> pneumonia alone	54	35	65%
<i>P. carinii</i> pneumonia and another disease	17	8	47%
Kaposi's sarcoma alone	5	3	60%
Kaposi's sarcoma and <i>P. carinii</i> pneumonia	1	0	0%
Kaposi's sarcoma and another disease	1	0	0%
One other disease alone	29	12	41%
Two other diseases alone	2	2	100%
Candidiasis	15	8	53%

Hospital charts of all 29 patients who were reported as having died within the month of or the month following diagnosis were reviewed and abstracted without names and addresses by the registered nurse responsible for confidential case reporting. Patient history, laboratory data, medications, method of payment, and any unique clinical features were ascertained for each patient through this review. The nurse obtained causes of death and education level from death certificates. From this information the numbers known to be HIV-positive before diagnosis of AIDS, education level, method of payment, and causes of death of the patients were tabulated. A physician then reviewed each abstract and traced the clinical history leading to diagnosis of AIDS as well as the patient's acute hospital course. Likely reasons for the short survival time from AIDS diagnosis to death were ascertained.

Results

Results from case reports:

Patients in the study cohort were living in 37 different Kentucky counties at the time of diagnosis with AIDS. Of the 124 cases in the cohort, 87% were male and 13% were female (Table 2). Of the subjects, 76% were white, 22% black, and 2% Hispanic. The cohort was distributed relatively equally throughout age groups. Men who have sex with men accounted for 68% of exposures, injecting drug users 9%, and subjects who had both exposures 7%. *Pneumocystis carinii* pneumo-

nia alone was the disease of diagnosis in 44% of cases, *P. carinii* pneumonia with another disease in 14%, and candidiasis in 12%.

At the end of the study period (18 months after diagnoses of the first cases in the cohort and 6 months after diagnoses of the last), the crude mortality ratio (the number of deaths divided by the number of cases) in the cohort was 45%. The ratio for whites was 46%, for blacks 48%, and for Hispanics 0%. For males the ratio was 47%, for females 31%. No statistically significant differences in sex, race, age of diagnosis, exposure

category, and disease indicative of AIDS were found between survivors and decedents.

Of the 56 patients who died, 41 (73%) survived only from zero to 3 months after diagnosis. Of these 41 patients, 29 (71%) did not survive the hospital stay during which AIDS was diagnosed (zero survival time). The survival times in each of the major subgroups are shown in Table 3. Of blacks, 85% survived less than 3 months, of whites 70% (OR 1.47, 0.55-3.86). Fig 1 compares survival times of black and white subgroups to the entire cohort.

Table 3. Survival Times of Reported Kentucky Adult AIDS Cases (Diagnosed July 1, 1990 through June 30, 1991).

	End of 3 Months	End of 6 Months	End of Study*	Totals
Entire Cohort	67%	65%	55%	124
Sex				
Male	65%	64%	53%	108
Female	81%	75%	69%	16
Race/Ethnicity				
White	68%	66%	54%	94
Black	59%	59%	52%	27
Hispanic	100%	100%	100%	3
Age at Diagnosis				
<30	76%	73%	61%	33
30-34	52%	52%	48%	29
35-39	70%	70%	56%	27
≥40	69%	66%	54%	35
Exposure Category				
Men who have sex with men	67%	65%	55%	84
Injecting drug use	73%	73%	64%	11
Men who have sex with men and inject drugs	57%	57%	43%	7
Hemophilia/coagulation disorder	33%	33%	33%	3
Heterosexual contacts	80%	70%	50%	10
Receipt of blood transfusions or components	57%	57%	57%	7
Other	100%	100%	100%	2
AIDS Index Disease at Diagnosis				
<i>P. carinii</i> pneumonia alone	74%	72%	65%	54
<i>P. carinii</i> pneumonia and another disease	59%	59%	47%	17
Kaposi's sarcoma alone	60%	60%	60%	5
Kaposi's sarcoma and <i>P. carinii</i> pneumonia	100%	100%	0%	1
Kaposi's sarcoma and another disease	0%	0%	0%	1
One other disease alone	57%	57%	41%	29
Two other diseases alone	100%	100%	100%	2
Candidiasis	67%	60%	53%	15

*Average follow-up of one year.

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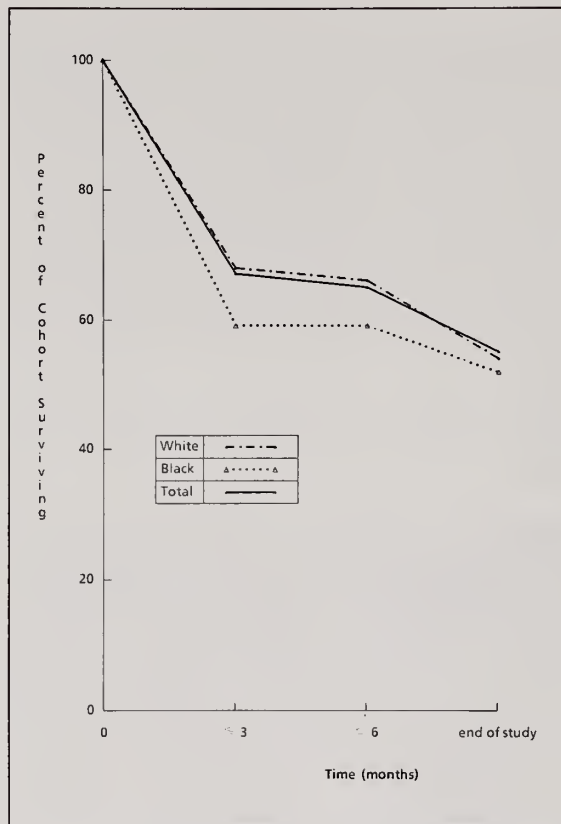


Fig 1 — Survival in Total Cohort of 124 Kentucky Patients with AIDS (Diagnosed July 1, 1990 through June 30, 1991) and in Two Subgroups

Because of the small numbers in cohort subgroups, the study lacks the statistical power to show significant survival differences. However, the data suggest that survival for 3 months appears to be less likely for blacks (OR 1.47, 0.55-3.86), for males (OR 2.35, 0.57-11.14), and for those 30 through 34 years old (OR 2.35, 0.92-6.02).

The first diagnosis of AIDS in cohort patients was made at 40 different hospitals with a median number of two cases per hospital. Only five hospitals admitted five or more cohort patients each. Patients presented to 77 different physicians.

Results from chart review:

The 29 patients who died during the month of or the month following diagnosis had presented to 22 different physicians at 15 different hospitals at the time of AIDS diagnosis. Only two of these survived to be discharged. *P. carinii* pneumonia was listed as the immediate cause of death on six death certificates, AIDS on five (Table 4). AIDS was listed as an underlying cause of death on 17 certificates.

Of the 23 patients for whom an education level was known, 21 had at least a high school education. Only three of the 24 for whom the information was available had no method of payment.

At the time of diagnosis of AIDS, 16 of the 29 (55.1%) patients were previously known to be HIV-positive. The most commonly identified rea-

Table 4. Causes of Death Given on Death Certificates of Chart-Reviewed Patients in Kentucky AIDS Mortality Study Cohort.

Immediate		Underlying	
Cause	Number of patients	Cause	Number of Patients
<i>Pneumocystis carinii</i> pneumonia	6	AIDS	17
AIDS	5	HIV infection	6
Pneumonia	4	<i>Pneumocystis carinii</i> pneumonia	3
Respiratory failure	4	Pneumonia	2
Sepsis	2	<i>Cryptococcus meningitis</i>	1
Kaposi's sarcoma	1	Cardiac arrest	1
Malignant lymphoma	1	Lymphoma	1
<i>Cryptococcus meningitis</i>	1	Hemophilia	1
Disseminated cryptococemia	1	Immunocompromised state	1
Bleeding ulcer	1	Pulmonary infiltrates	1
CNS toxoplasmosis	1	Leukoencephalopathy	1
Intracerebral hemorrhage	1	Renal insufficiency	1
Disseminated <i>Mycobacterium avium</i>	1	<i>Staphylococcus aureus</i> pneumonia	1

son for short survival time from AIDS diagnosis to death was a missed diagnosis (in 10 of the 29 patients — 34%), (Table 5). Five patients failed to seek care until gravely ill. Five patients had actually met the case definition weeks to months earlier but were reported as a new case with a new opportunistic infection.

Comments

The findings of the study, particularly those that relate to the relationship of HIV-positive persons with the medical care system in Kentucky, are intriguing. During the study the authors were impressed by the frequency with which even those known to be HIV-positive for some time had apparently received little or no care for their infection during the interim.

Clearly, considerable numbers of persons with HIV infection are either not utilizing the existing HIV counseling, testing, and follow-up systems or are not receiving medical care for their infection once it is identified. It is unknown how many of the patients in this study who were not known to be HIV-positive until shortly prior to death may have had a previous positive test at an anonymous testing site. Such a person may have failed to return for a test result or may have been given the result but failed to seek medical care.

More extensive routine confidential testing in settings likely to see persons at high risk for HIV infection should be considered. Those who are tested anonymously must be clearly informed that they should expect to retain their anonymity only if the test result is negative. The statewide HIV care coordinator system, which became fully operational in 1991, should prevent many patients from being lost to medical follow-up.

The medical review of patient charts suggested that the scatter of caregivers may have resulted in some errors in diagnosis and treatment decisions. A study by Charles L. Bennett, MD, and colleagues in *Archives of Internal Medicine* found that in-hospital mortality from *P. carinii* pneumonia was less likely if the facility had a higher familiarity with AIDS.⁹ However, it is difficult to know whether centralization of care for persons with AIDS in Kentucky would improve their survival, and even more difficult to know what a state public health agency can or should do to influence that kind of decision.

The Kentucky Medical Association and the Department for Health Services have worked to-

Table 5. Likely Reason for Short Survival Time from AIDS Diagnosis to Death of Chart-Reviewed Patients in Kentucky AIDS Mortality Study Cohort.

Reason	Known to be HIV +	Not Known to be HIV +	Total Number
Diagnosis missed by one or more physicians	1	9	10
Failure to seek care	0	5	5
Actually met case definition earlier	5	0	5
Last to follow-up	4	0	4
Did not meet case definition during most of last stage of illness	2	0	2
Prisoners—no record of specific HIV-related care	2	0	2
Apparently inadequate follow-up	2	0	2
Intercurrent death	1	0	1
Elderly with other medical problems	1	0	1
Noncompliant with treatment due to cost	1	0	1
Total	19	14	33*

*Four cases had two reasons each

gether over the last several years to encourage physicians throughout the state to be willing to care for persons with HIV infection. At the same time, several adult and pediatric infectious disease specialists in Lexington, Louisville, Cincinnati, and Nashville have acquired considerable expertise in treating the condition. The issue merits further debate. In the meantime, the Department for Health Services continues its commitment to timely surveillance, investigation, and consultation regarding HIV infection and AIDS.

ACKNOWLEDGEMENTS: We wish to thank Mollie Adkins and Joyce Bothe for assistance with data collection; Jeff Hughes for data analysis assistance; Ben Yandell, PhD, for assistance with the analysis and manuscript review; the staff of individual hospitals for access to records; and Marian McKee for assistance in manuscript preparation.

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Guest Comments Ardis D. Hoven, MD

The data published by Ms Stapleton and her colleagues in this issue of *The Journal* are clearly disturbing but nonetheless capable of being significantly improved. The most common identifiable cause for short survival time from the time of AIDS diagnosis to death is that of *failure* to make the diagnosis of either HIV infection or the AIDS defining illness.

Although Kentucky's incidence of AIDS is lower significantly than the national average (cases per 100,000), Kentucky physicians must be continually alert to the risk factors for HIV disease and the clinical presentation of HIV/AIDS related illnesses. Continued medical education in this area is extremely important and justifiable.

Equally as important in this equation is the early diagnosis of HIV infection and the ongoing medical care and preventive treatments which have clinically been documented to prolong survival and diminish the risks of opportunistic infections. Educating patients at risk for HIV disease to seek early counseling and testing, encouraging patients to seek early medical care, and removing the discriminatory barriers are equally as important in our efforts to diminish the morbidity and mortality associated with HIV infection.

My thanks to Ms Stapleton and her colleagues for this data and may we use it to improve the quality of care we render.

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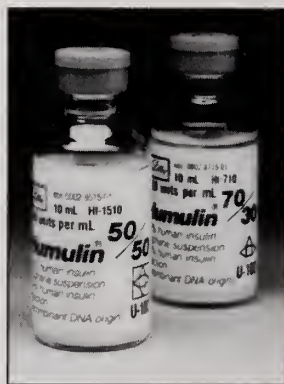
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Solitary Fibrous Tumor of the Pleura with Hypoglycemia: The Doege-Potter Syndrome

Thomas M. Roy, MD; Mark V. Burns, MD
David J. Overly, MD; Bryan T. Curd, MD

The occurrence of hypoglycemia with an intrathoracic tumor was reported in 1930 independently by Doege¹ and Potter.² Since then, the presence of a nonpancreatic tumor associated with low blood sugars has often been referred to as the Doege-Potter syndrome. We report a patient with a recurrent solitary fibrous tumor of the pleura who experienced symptomatic hypoglycemia attributable to his tumor.

Introduction

Hypoglycemia secondary to tumors is rare. Following the initial report of symptomatic hypoglycemia with a mediastinal tumor, similar lesions in other organs have been described. The majority of these tumors are mesodermal in origin and are anatomically related to mesothelial surfaces.³ The mesenchymal tumors of nonpancreatic origin causing hypoglycemia include fibrosarcomas, hemangiopericytomas, leiomyosarcomas, hepatomas, mesotheliomas (solitary and diffuse), and fibromas.⁴

The major anatomic distributions of these neoplasms has been determined from clinical study.⁵ An abdominal location is most common and represents the site for 65% of these tumors. Thirty percent of such tumors will be found in the thorax. Only 5% of these tumors will occur elsewhere in the body.

The intrathoracic malignancy most often cited as causing hypoglycemia has been mesothelioma. Low serum glucose has been found in patients with the aggressive, environmentally-caused, diffuse malignant mesothelioma.⁶ However, hypoglycemia is more commonly associated with large solitary fibrous pleural tumors,

often referred to as benign mesotheliomas.⁷

A patient with recurrent solitary fibrous pleural tumor and symptomatic hypoglycemia is presented. A current profile of this clinical entity and its potential for causing the Doege-Potter syndrome has been constructed from the medical literature.

Case Report

E.C. is a 77-year-old male whose family summoned EMS after he became weak, disoriented, and uncommunicative. His blood sugar was determined to be low by the chemstick method enroute to the hospital. His level of consciousness improved immediately with the administration of one ampule of D50W. When he was formally evaluated in the emergency department, his mental status had returned to baseline. His daughter related that he had a similar episode one week earlier and his serum glucose had been measured at 40 mg/dl.

He was afebrile, but tachycardic with a rate of 108 beats per minute. His respiratory rate was recorded at 24 breaths per minute. He was oriented and cooperative. After the administration of additional glucose intravenously, he was in no acute distress. A well-healed right thoracotomy scar was present. Breath sounds were significantly diminished over the right hemithorax. The remainder of his physical examination was unremarkable.

On repeat measurement, the serum glucose was 32 mg/dl. The remainder of his chemistries were normal. Complete white blood cell count and urinalysis were normal.

After his mental status corrected, it was learned that he had a mesothelioma removed

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The Doege-Potter Syndrome



Fig 1 — Chest radiograph 8 years after second surgery showing recurrence of a solitary pleural based tumor at the site of initial excision.



Fig 2 — Patient's chest radiograph 3 years later shows that the tumor has significantly increased in size and occupies the greater part of the right hemithorax.

from his right lung in 1965. This tumor recurred and was again resected from the same site in 1980. The pathology of the second tumor was consistent with a spindle cell low grade mesothelioma. He and his daughter were aware that a chest radiograph in 1988 indicated that the tumor was developing in this area yet a third time (Fig 1). It was their impression that this recurrence was a benign event that required no further evaluation. Interestingly, his medical record contained no evidence that the growth of this tumor was being monitored.

A large, rounded, soft tissue density was seen in the right hemithorax on standard chest radiograph (Fig 2). From computerized chest tomography, it could be determined that the tumor was connected to the pleura by a pedicle or stalk (Fig 3). This study measured the tumor as $14 \times 12 \times 9$ cm in size. Other imaging studies failed to show evidence of distant metastasis. No abnormalities of the pancreas, liver, adrenals, or brain were evident.

During his hospitalization, the patient would predictably develop symptomatic fasting hypoglycemia that could easily be countered by scheduling three full meals and three or four carbohydrate snacks. A thorough evaluation by the endocrine service determined that the patient's hypoglycemia was secondary to secretion of an insulin-like substance from the patient's tumor.

Surgical resection was considered to be high risk due to the patient's age, his pulmonary compromise, and the scar tissue from prior thoracotomies. The patient and family declined surgery after the risks were explained to them by the thoracic surgery service. His hypoglycemia has been controlled with frequent feedings and home glucose monitoring.

Discussion

Solitary fibrous tumor of the pleura has traditionally been described as a localized fibrous mesothelioma or a benign fibrous mesothelioma. Although this intrathoracic tumor is adherent to a serosal surface, recent histochemical and electron microscopic techniques suggest a mesenchymal non-mesothelial cell origin.⁸ This genesis would make it an entity distinct from true mesothelioma. As a separate tumor, the dramatic difference in biological behavior and prognosis compared to diffuse inoperable mesothelioma is better understood. It has been suggested that the term "mesothelioma" be avoided when referring

to a solitary fibrous tumor of the pleura. This admonition will be difficult to follow, however, since the earlier terminology is well entrenched in the medical literature.

While diffuse mesothelioma has a uniformly poor prognosis, a solitary fibrous tumor of the pleura is most often curable by resection. Likewise, it lacks any association with asbestos exposure. This distinction is important since such occupational exposure is medicolegally linked to diffuse mesothelioma.

The tumor is relatively uncommon. Only 600 patients with solitary fibrous tumor of the pleura have been reported in the medical literature from 1930 to 1989.⁸ Observations from this small population suggests that the tumor occurs equally in both sexes and in all age groups. Most commonly, it is diagnosed in the sixth and seventh decades of life with a median patient age of 57 years. It may be discovered as an incidental radiographic finding in asymptomatic individuals and appears as a circumscribed, lobulated, pleural based mass. It may also be discovered as the cause of dyspnea, cough, or chest discomfort. Digital clubbing and hypertrophic pulmonary osteoarthropathy often occur with large tumors.⁹

Rarely, hypoglycemia will be a prominent symptom. The association between solitary fibrous tumor of the pleura and hypoglycemia has been reported in less than 20 patients.¹⁰ In one study, 10 of 12 tumors associated with hypoglycemia were located in the right hemithorax as seen in our patient.⁸ For some unexplained reason, hypoglycemia has occurred three times more frequently in females as in males.¹¹

A consensus explanation for the hypoglycemia associated with solitary fibrous tumor of the pleura has not yet been recognized. The etiology is probably heterogenous and multifactorial. A number of hypotheses have been proposed.

Increased utilization of glucose by the tumor has been proposed as one important factor causing hypoglycemia. Generally, the fibrous pleural tumors found in patients with hypoglycemia are larger than 10 cm in diameter.¹¹ They frequently weigh from 1 to 2 kilograms at the time of surgical resection. It has been calculated that a mesenchymal tumor could consume approximately 200-300 grams of glucose per kilogram of tumor weight per day.⁴ While this tumor metabolism may contribute to a lower serum glucose, it is not sufficient to account for the degree of hypoglycemia witnessed with these tumors.

Ectopic secretion of insulin was proposed by

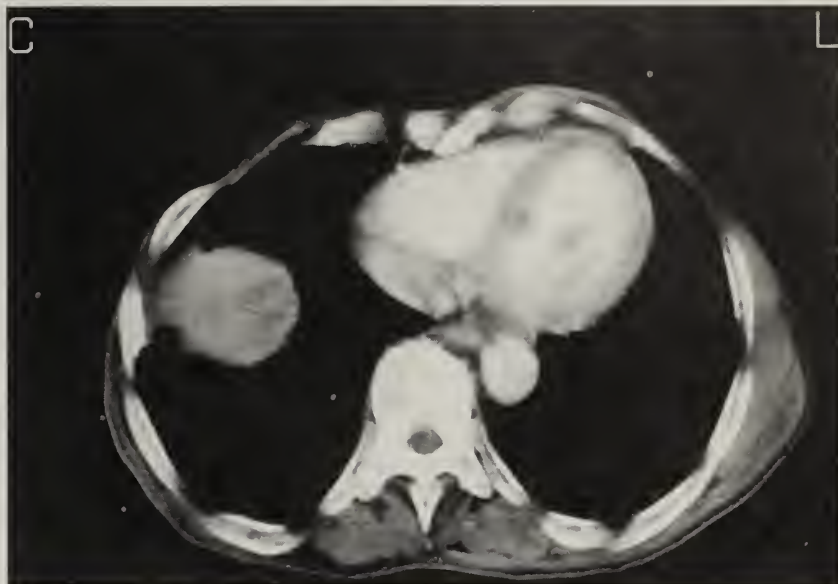


Fig 3 — Computerized tomography section of the chest clearly shows the pedicle that attaches the tumor to the pleura.

early investigators. They noted that the ultrastructural features of the mesenchymal tumor cells possessed certain organelles that were similar to those described in insulinomas.¹² The hypothesis of ectopic insulin secretion is not supported by serum immunoreactive insulin (IRI) assays. These are typically normal or diminished in the setting of tumor-induced hypoglycemia.^{4, 13} The IRI assays are typically negative when applied to tumor samples as well.

Secretion of an insulin-like substance by the tumor has gained popular acceptance. A purified serum peptide with insulin-like activity was identified using a specific radioreceptor assay.¹⁴ This glycoprotein has a molecular weight of 90,000 and is termed the non-suppressible insulin-like active substance (NSILA-s). Elevated titers of this compound in the context of tumor-induced hypoglycemia suggest a role in the genesis of the Doege-Potter syndrome. Most recently, isolation of an insulin-like growth factor (IGF-I) from a solitary fibrous tumor of the pleura was reported.¹¹ This finding suggests that the tumor may be able to manufacture more than one type of NSILA-s.

All tumor hypoglycemia cannot be explained by the above observations. Fasting hypoglycemia has been documented in a patient with a histologically benign mesothelioma whose serum insulin was low, somatomedin-like activity of the serum was not elevated, and NSILA-s was not

The Doege-Potter Syndrome

detected.¹⁵ Deficient glucagon secretion with an apparent decrease in glycogenolysis was considered the cause of hypoglycemia. A tumor substance that would primarily affect the liver or pancreatic alpha cells was proposed.

Regardless of its cause, the low blood sugars are commonly remedied by surgical excision which is also the treatment of choice for solitary fibrous tumor of the pleura. Approximately two-thirds of these tumors are pedunculated and attached to the visceral pleura by a pedicle that contains prominent vessels. The remainder will arise from the parietal pleura along the chest wall, diaphragm, or mediastinum.⁸

The tumors are categorized as benign or malignant based on histologic criteria. In just over a third of these tumors the presence of increased cellularity, pleomorphism, mitosis, hemorrhage, and necrosis will imply microscopic malignancy.⁸ It must be emphasized, however, that this histologic designation does not necessarily reflect an aggressive biological behavior. Histologically malignant tumors that are pedunculated can often be totally resected for permanent cure.⁵

The most dependable predictor of clinical benignity is resectability. By this criterion approximately 80% of localized fibrous tumors of the pleura have a benign course. Surgical cure approaches 100% for lesions that are histologically benign and 45% for lesions that show histologic features that are considered malignant. Tumors that invade the diaphragm, lung, and chest wall, or are only partially resectable, are the most likely to metastasize.

The necessary surgical procedure is usually simple excision with a small wedge resection of lung tissue. Occasionally, segmentectomy, or lobectomy is required. Rarely, radical excision to include portions of chest wall and ribs is necessary. The potential for intraoperative complications is high.¹⁶ Because of the bulk of the tumor, mediastinal structures and the diaphragm often cannot be seen intraoperatively. This may result in inadvertent injury to neighboring organs. The pedicle of the tumor is quite vascular and massive bleeding may occur if the tumor has more than one connection to the pleura. Finally, cardiac arrest has occurred due to shift of the mediastinum upon tumor removal.¹⁶

Recurrence of resected tumor is unusual but is reported, especially with the malignant variety. A prolonged latent interval between resection and recurrence has been observed. The tumor always recurs on the same site as the primary and

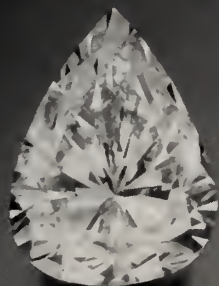
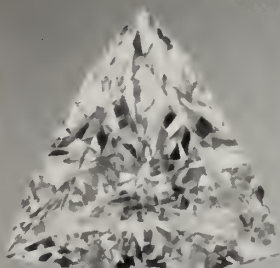
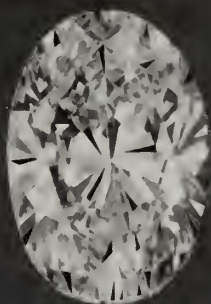
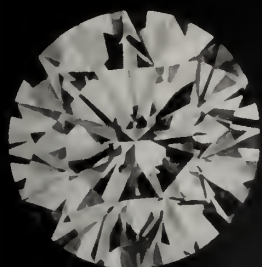
almost always at the site of the initial excision. This phenomenon is illustrated in our patient by the third occurrence of the tumor at the same site over a 27-year period.

In summary, the immunoprofile of a solitary fibrous tumor of the pleura suggests mesenchymal differentiation rather than mesothelial cell proliferation. In this respect, it does not pursue the same aggressive and dismal course as a true mesothelioma. The tumor is rare but important since resection typically affords cure and relief of constitutional symptoms that may include hypoglycemia, clubbing, and pulmonary osteoarthropathy.

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Successfully defending a brain-damaged baby case is the courtroom equivalent of pitching a no-hitter. Because the "sympathy factor" can add millions to a jury's award, many insurance carriers would rather settle than fight.

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There's more in these numbers than luck. "It's even legal skill," adds JMT&K founding partner Aaron Jacobson, who was one of Ohio's leading plaintiffs' lawyers before he, Larry E. Rogers, Herbert S. Bell, M.D., and 71 other Cleveland doctors formed P-I-E in 1975.

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By Howard Eisenberg

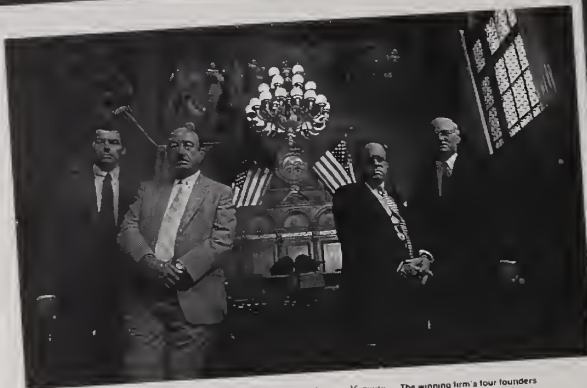
discouraged the filing of many other cases. Plaintiffs' attorneys have learned that we're fair negotiators when our doctor's in the wrong, but won't back down when he's right."

That approach pays off. "According to the most recent report I've seen from the General Accounting Office," says Larry Rogers, P-I-E president and CEO, "in 1984, about 57 percent of medical-malpractice claims were closed without payment. Through 1988, we've closed an average of 78 percent of our cases without a dime changing hands. And it's my understanding that, without including defense costs, St. Paul Fire and Marine Insurance Co.'s 1988 average gross payout for cases closed in Ohio with payment was \$52,500. Our comparable figure was about \$10,000 below

there. That's partly why we can sell an OBG specialist in Ohio—an industrial state that ranks among the most litigious—\$1.2 million in coverage for just \$28,000."

The unique marriage of P-I-E and JMT&K has been so successful that the carrier has expanded into five other states: Indiana, Kentucky, Maryland, Missouri, and West Virginia. Where P-I-E goes, there goes JMT&K, with nine branch offices to date. The firm has 15 trial attorneys, and may well be the nation's largest devoted well-nigh exclusively to medical-malpractice defense.

Could the insurer-defender symbiosis, if duplicated by other doctor companies, make a significant contribution to reducing malpractice litigation nationwide? An up-close look at



how JMT&K operates may help to answer that question.

Every lawyer develops a medical specialty

"Our firm's lawyers read more medical books than law books," says P-I-E Vice President Gerard C. Oppenorth, himself a veteran defense attorney. Robert Maynard explains, "New cases are discussed at our weekly staff meeting so that every lawyer is familiar with every case. But we assign cases to our attorneys according to medical specialty. They're well-versed in their fields, so they don't have to reinvent the wheel with each case."

Last year, the firm's OBG specialists, attorney Jerome S. Kalur, who had won 16 consecutive brain-damaged baby cases, faced one of his toughest challenges when he defended a GP

who'd attempted a midforceps delivery that ended in a Cesarean section and a severely brain-injured baby. Recalls Kalur, "I didn't think the doctor had caused the damage, but our position was weakened by the fact that he didn't have midforceps privileges. Based on that departure from the standard of care, our doctor panel voted to settle, and, since the hospital was also involved, a combined sum of \$1.5 million was offered. Plaintiffs turned us down flat."

"I wanted to depose the doctor, who'd been involved in the mother's care during her hospitalization, but the attorney for the plaintiff baby insisted it would violate the mother's physician-patient confidentiality. That privilege would terminate automatically when her medical

records were introduced at the trial end of the plaintiff's case. Meanwhile, I was in the no-win position of having to tell the jury, 'It couldn't have been the midforceps, without offering them another reasonable brain-damage theory.'"

Fortunately, the plaintiffs rested their case on a Friday afternoon, giving JMT&K time for a weekend rally. "Twenty minutes later," says Kalur, "I was in the hospital pathologist's office with an order permitting me to view the mother's placental slides." Meconium staining had been charted, and Kalur had begun long before the for-

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Does Kentucky Need A Primary Care Medical School?

William J. Hueston, MD

... The real mission of medical schools is fame, money and power through biomedical research. There is increasing recognition that the system has failed its societal responsibility, and that the time is ripe for a change. — ALAN DAVID¹

The quotation above, taken from an address given by a former medical educator in Kentucky, is not only a sad commentary on our medical education system as a nation, but is diagnostic of the problems with medical education in Kentucky. Despite two state supported medical schools, over 80 of this state's counties lack adequate primary care physician manpower. And this problem will not be solved in the next few years. Based on data from the 1990 resident match, only 13% of Kentucky medical school graduates, 15.3% from the University of Kentucky and 11.3% from the University of Louisville, started their residency training in family medicine.² Thus, as the more experienced general practitioners who have traditionally served as the source of medical care in the state's rural counties retire, there will be a dearth of new family doctors to take their places.

The problem of decreasing supplies of primary care physicians is not Kentucky's alone. Research shows that in 1983 nearly half of all students who entered US medical schools had plans to enter a primary care

specialty, but that during the course of their medical school career, two-thirds of these students switched their preference to sub-specialty fields.³ Further research shows that this trend is only worsening: by 1987 only 23% of students who showed an initial preference for primary care specialties actually chose residencies in these fields.⁴ These alarming trends suggest that the national supply of family physicians will fall far below the numbers needed to continue to provide adequate health care,^{5,6} particularly in rural areas which most often are served by family doctors.⁷

As a reaction to these observations, several remedies have been proposed and many of these have been implemented.^{8,9} The strategies that have been adopted include the creation of state-supported medical schools dedicated to the training of primary care physicians.⁸ Examples of such schools include the University of Minnesota-Duluth, Wright State University, and Southern Illinois University, each of which has enjoyed success at training future primary care doctors. At the University of Minnesota-Duluth, a 2-

year school for students who finish their final 2 years of clinical education at the University of Minnesota in Minneapolis, 52% of students enter residencies in family practice.¹⁰ That is why I have contended that Kentucky may need to follow these examples and establish a new primary care medical school.¹¹

Why a new medical school? Why not restructure our current medical schools to meet the primary care needs of our state? Unfortunately, curriculum revisions and other inducements such as the rural health scholarship have been tried and have not met with success. Most of these attempts have failed for reasons noted by Alan David in the quote that begins this article. While the mission statements of Kentucky medical schools may allude to the production of primary care physicians, to a large extent the actual role of these medical schools is to serve as support structures for the tertiary care facilities around which the medical schools are structured. This co-habitation of tertiary care and medical education has a great influence on impressionable medical students, particularly on those who are saddled with a large post-training debt. Despite attempts to sway medical students in the direction of primary care with ambulatory care or family medicine clerkships early in the clinical years, research suggests that the decision to choose a primary care career is made during the first 2 years of medical school.¹² Comprehensive primary care

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Primary Care Medical School

programs that begin on the first day of medical school and which offer primary care physicians as mentors are the most successful means of persuading students to pursue primary care positions.¹³ With the power structure of traditional medical schools tipped towards the biomedical researchers who control the first 2 years of training, such programs are difficult if not impossible to initiate.

As noted above, several other states have faced a dilemma similar to Kentucky's and, tired of wrestling with resistant university medical faculty, have responded to the underproduction of primary care physicians by establishing a primary care medical school. The following section outlines some models for primary care medical education which could be adapted in this state.

Primary Care Medical School Models

1. *The Two-Year Preparatory Model*

One of the largest obstacles facing community medical student training is the availability of a medical center with a patient base large enough to support the myriad training needs of a large group of medical students. One strategy to deal with this problem is the establishment of a medical school which offers only the first 2 years of medical training with students transferring to other medical schools for the final 2 years of training. During these 2 years of training students receive the basic pre-clinical education, but this is spiced with a large dose of primary care experience.

The most well-known example of this model is the University of Minnesota-Duluth program which includes an innovative family practice preceptorship program. During their 2 years of training, medical students spend a significant portion of time working with community family physicians and other primary care

physicians. This experience begins with brief introductory sessions during the first year of training where students are assigned to a local family physician. Students spend a minimum of 10 half-days spread over the first year with the mentor. During the second year of training, the student is paired with a rural family physician and spends a 3-day stretch with this physician during each quarter of the year. Thus, this program only consumes 5 total days of the curriculum in the first year of school and 12 days in the second year. Yet, the results are dramatic. Based on 9 years of experience, almost 53% of trainees ultimately enter family practice, with an additional 20% entering other primary care fields such as internal medicine, pediatrics, and obstetrics/gynecology.

For Kentucky, the advantages of such a program are clear. A 2-year school would require fewer clinic faculty than a 4-year medical school. At the University of Minnesota-Duluth, in fact, there are no clinical departments except for a single clinical medicine department which is staffed primarily with primary care faculty. Additionally, with several regional universities at its disposal, Kentucky can draw from a biological science faculty that is already established. Additional faculty in such areas as anatomy, biochemistry, physiology, and development may be necessary to bolster the science department of a regional university, but this will also serve to improve the undergraduate biology programs at these institutions.

2. *The "School Without Walls"*

All medical schools do not include a mammoth university hospital where medical students perform their clinical rotations. Other medical schools, particularly those which were developed with a primary care mission, utilize regional hospitals across their states for the clinical training of students. Examples of these

include Michigan State University where students spend a large portion of their training at one of several regional sites and the University of South Dakota where students are assigned to one of three clinical campuses across the state. These programs, however, are not as successful in producing primary care physicians. Over the past 10 years neither of these two schools has produced significantly more family physicians than the University of Kentucky.

One difficulty with the medical schools used above as examples is that there is little difference between the medical school curriculum in their programs and that of more traditional schools. With a notable exception to be discussed below, most of these students receive a basic pre-clinical education and then are shunted off to large medical centers for their clinical training. A reflection of this is seen at the University of South Dakota where a majority of the school's Department of Family Practice is not even at the university, but is located over 60 miles away in Sioux Falls.

An exception to the poor primary care record for schools without walls is one of the clinical campuses of Michigan State University. The clinical campus at Escanaba, a small town in the upper peninsula of Michigan, has an excellent track record for producing primary care doctors.^{9,14} This program is similar to the preceptorship program at the University of Minnesota-Duluth, with the exception that students are placed with medical school faculty mentors in the community rather than with more distant preceptors. Follow-up of graduates has shown that physicians are more likely to practice family medicine and to practice in rural locations than graduates who trained at larger medical centers.¹⁴

3. *The Combined Undergraduate/Medical School Curriculum*

This model is based on the curriculum developed by the University of Missouri-Kansas City which melds the undergraduate and medical school curricula into a single unit. Medical school issues and courses are begun early in the student's academic career which gives the faculty an early opportunity to introduce the concepts of primary care. For example, in the first year of school students are given a medical advisor who is usually a primary care physician.

Advantages of this model include the ability to accelerate the education of future primary care physicians. One of the provisions of Senate Bill 239 passed in 1990 directs both the University of Kentucky and University of Louisville to adopt mechanisms which will enable primary care physicians to be prepared in 6 years. Combining the undergraduate and medical school curricula may be one such mechanism. By shortening the duration of training by 2 years, the burden of debt accumulated by future physicians will be substantially reduced, which may enable students to enter primary care specialties who may otherwise opt for more lucrative subspecialties because of overwhelming financial burdens. Second, the integration of the medical and undergraduate curricula will reduce the redundancy that currently exists in medical education. Under the current system, undergraduate students who concentrate on the biological sciences so that they will qualify for medical school are not free to use their undergraduate time for other pursuits such as the humanities. Under a combined curriculum, students can use their undergraduate time to study other fields, which will result in more well-rounded physicians.

The combined curriculum model can stand on its own or can be incorporated into one of the two models presented above. One can imagine a 4 year combined

curriculum at one of the state regional universities with the student shifting to other clinical campuses including either the University of Kentucky or Louisville for the final 2 years of clinical experience. However, some may believe that 6 years is not enough time. Those who have these doubts can be referred to the British medical education system which takes students out of the British equivalent of high school and trains them as physicians in 5 years. Certainly if the British can produce physicians in 5 years, we can do it in 6.

Planning and Funding a Primary Care Medical School

Whenever new proposals are generated, the basic question that must be answered is: Is implementation of this proposal impossible and impractical, or is it possible but requires difficult decisions? A primary care medical school in Kentucky is not impractical, nor is it impossible, but it will require some very difficult and very upsetting decisions.

The most difficult decision will be: Who will pay for such a school? In addition to state funds, federal grants and other foundation grants may be needed to tackle the huge start-up costs of a new medical training program. Fortunately, rural health care and community-based medical training are priorities of many philanthropic agencies such as the Robert Wood Johnson Foundation and the Kellogg Foundation. With the shifting focuses of foundations, though, this opportunity may soon be gone. Even with large outside contributions, the burden of funding a new medical school will fall upon the public.

The basic paradigm that underlies all our decisions should be the establishment of priorities. Is primary care, and in particular, rural primary care, a priority for Kentucky?

With the vast majority of our rural counties lacking the necessary primary care manpower to offer adequate care to our citizens, I think it is. But how much of a priority is it? In an era of budget constraints, for every new idea enacted, something else must be sacrificed. Our state planners must balance the benefits of high-cost specialty programs such as bone marrow transplantation programs, heart transplantation programs, gamma knives, and other technologies which are high cost interventions benefiting few, versus the advantages offered to many others due to the increase in primary care physicians. Funds may have to be shifted from the university medical school programs for a primary care medical school. High technology is glamorous; primary care, like all preventative strategies, is not glamorous, but it does make sense.

Conclusion

So, the bottom line should not be: Can Kentucky afford a primary care medical school? But, rather, the question we should be asking is: Can we afford not to have one? With access to care denied to a large portion of our rural populations, our health as a state will only worsen. Unless we make a dramatic move to shift new physicians into primary care positions, our citizens will present later in the course of their illness. If we do not refocus our attention from specialty to primary care training, we will find ourselves relying upon our tertiary care institutions even more, only this time to care for those who could have been helped earlier if only someone was there.

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CAGE Questionnaire

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C = Have you ever felt you should cut down on your drinking?

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These are days in which we seek to be “computer-friendly” and to find products that are “user-friendly.” What about supporting actions which are “family-friendly” if doing so does not place an excessive burden on our resources?

The hours we keep in medicine are not necessarily “friendly” toward maintaining strong and supportive family relationships. There is also a ripple effect, as we often expect a similar degree of dedication and loyalty from those who work for us. As a result, while our offices may exist to improve and assist others’ lives, they are not always “family-friendly” for our employees.

There is much about our lives in medicine over which we have little control, but we could support lifestyle measures which support and enhance the lives of our own employees and our nation’s citizens. Few would debate that it is just and correct to *keep a job available* for a woman while she is both recovering from the process of childbirth and adjusting to the family changes attendant to the addition of this new and wonderful life. Few would begrudge employees days or weeks when major family illnesses redelineate a worker’s priorities. The very real need to watch over a family member, assist in his care and lend the support necessary

to feel one has done all that one could is vital to that worker’s physical and psychological “wellness.”

Legislation that would protect people from employers who seize on the opportunity of maternity leave or family related illness absences to “clean house” is really not so burdensome as some fear. A bill to this effect has been before Congress twice, most recently as this editorial went to press. It sought only to provide protection at the federal level that would *keep a job available* for up to 6 weeks for maternity leave or family illness: unpaid leave, . . . just job protection. Isn’t that really a worthwhile expenditure, a minimal inconvenience with a maximal, positive impact for all?

Like Arnold Schwarzenegger, . . . it *will* be back. Organized medicine should break from its traditional posture on this issue, and next time it is introduced, speak up on behalf of a measure that supports the physical and psychological wellness of all our citizens. . . . *Sometimes promoting wellness means enabling others* to do what they need to to respond to a personal crisis without the fear that doing so will cost them their very livelihood.

Martha Keeney Heyburn, MD

KMA 1992-93

PRACTICE MANAGEMENT SEMINARS

November 1992						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
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29	30					

How to Get Through the Medicare Maze

10 Louisville

11 Lexington

How To Get Started in Practice

12 Lexington

December 1992						
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How to Get Through the Medicare Maze

1 Northern Kentucky

2 Louisville

3 Owensboro

January 1993						
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31						

Gearing Up For Retirement

20 Louisville

CPT Coding

Financial Control in 30 Minutes (2 hour)

26 Lexington

27 Louisville

28 Northern Kentucky

February 1993						
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27	28					

Profitable Practice

16 Louisville

17 Lexington

Reception Techniques/Better Collections

18 Lexington

March 1993						
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27	28	29	30	31		

Marketing Techniques

10 Northern Kentucky

11 Louisville

How To Get Started in Practice

12 Louisville

For more information on these workshops, contact:

Kentucky Medical Association

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A Message From Priscilla Gerber 1992-93 AMAA President



Priscilla Gerber

I wish that I could meet and talk with each of you personally. But since that isn't possible, I am pleased to have this forum for sharing the message I will be bringing to those of you I do have the privilege of meeting during this year.

You may be aware that in June, the AMA Auxiliary celebrated 70 years of volunteer accomplishments for the people of this nation. Yet as we begin this new auxiliary year, the challenges that face us are every bit as great as those faced by the people who founded this organization. Women, children, and the elderly are suffering the consequences of the terrible epidemic of family violence. Dysfunctional families contribute to a downward cycle of crime, loss of hope, and poverty. Youth lack the skills to make the lifestyle choices that will stop the decline in their health. Many of the nation's citizens lack access to medical and health care.

In the past, challenges such as these have been met with commitment. And we must do the same today. But commitment must be more than a word. We must accept it as individuals and share it within this organization and with the medical

community. For only individual and shared commitment will enable us to make time where there is none, to transform promise into reality, to turn bold words into action, to find solutions to the problems that plague our world today.

We have what it takes to meet these challenges — a diverse membership, the respect of our local communities, the backing and cooperation of organized medicine, a history of volunteer achievement. Now, we must commit ourselves to give in return as much as we have received. For only then will we reach our vision of the future — a vision of volunteer leadership made rich by the diversity of our membership; of healthy, whole communities where people work and thrive and where our youth have hope for the future; of a nation in which quality and access to health care are assured. And all because we have the commitment to make it so.

Priscilla Gerber

"Only individual and shared commitment will enable us to make time where there is none, to transform promise into reality, to turn bold words into action, to find solutions to the problems that plague our world today."

Medical Malpractice — 1993 and Beyond

Manny Buzzell

Medical malpractice insurance. The words are bittersweet to the ears of most physicians. Some have lambasted medical malpractice insurance as a necessary evil while others have praised it for enabling physicians to enjoy a worry free environment to practice medicine.

Today, medical professional liability insurance is available and competitively priced in Kentucky. But this was not always the case. In the following article, I describe how we arrived at today's medical malpractice insurance market, what to look for in an insurer, and what to expect in the very near future.

A historical perspective

Physicians often hear the phrase "medical malpractice crisis." That's because medical malpractice insurance has been a volatile commodity for almost 20 years. In fact, many Kentucky physicians will remember when the crisis hit their home state in the mid to late 70s.

The initial crisis came in 1975 to 1976. Since then, claims frequency has risen and fallen periodically. However, claims severity — or the amount paid out in individual medical malpractice claims — has steadily increased (Fig 2). Interestingly, unlike most types of insurance, medical professional liability insurance not only looks at historical risks and costs, but also attempts to predict the future of these claims. After all, many claims do not materialize for years, with the more serious taking 5 to 8 years or more.

Frequencies Per 100 Doctors — Class 1 Equivalent

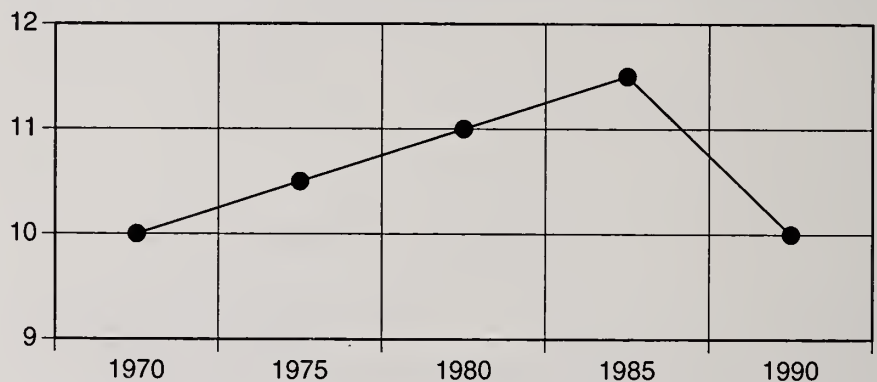


Fig 1 — Frequency of Claims: The actual rise by year was not as smooth as this simplistic graph illustrates — 1986 showed a drop of almost 10%.

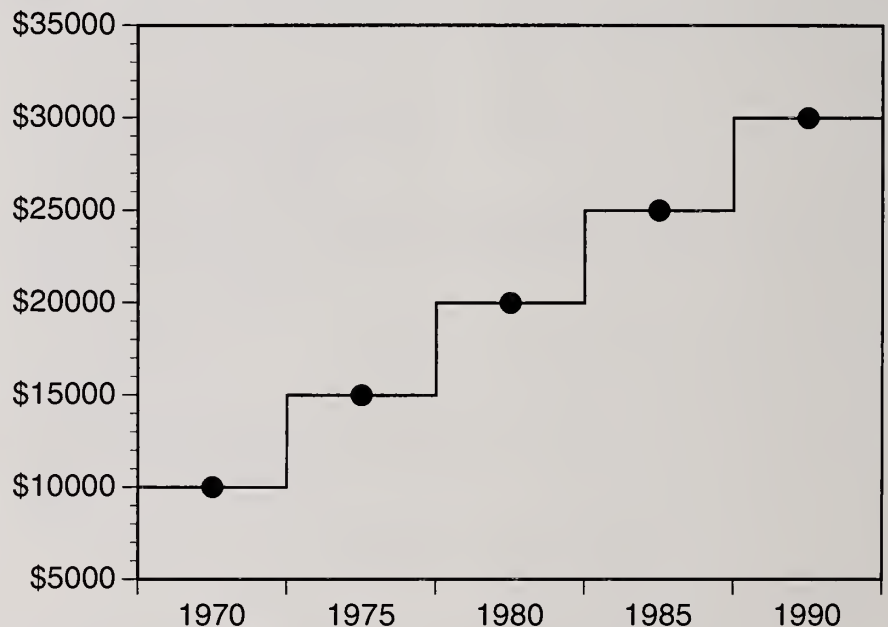


Fig 2 — Severity of Claims: Over the same time frame the severity (cost of the average claim) has increased steadily, again not in a specific percentage each year but in a stair-step basis.

As we look back on the past two decades and these corresponding trends, we see some good news and some bad news. The bad news is that we will probably not see significant rate reductions in medical malpractice insurance premiums. The good news is that the medical malpractice insurance crisis has encouraged state medical associations to form their own insurance companies. Many of these companies are stable and competitive, and remain an excellent source for physicians to obtain insurance.

Setting premiums

The process of setting premiums is based on carefully analyzed data. The analyzing is done by an actuary (an expert in assessing risk and establishing premiums).

Actuaries look at data from the last 4 to 6 years. They look for trends as well as other factors that may affect the claims environment. A best case/worst case and most likely case risk scenario is constructed. The insurer then files rates based on the actuaries' findings. These trends make the old axiom "they tell you where to drive by looking out the back window" quite appropriate for the medical malpractice industry.

It is worthwhile at this point to discuss some of the companies (mostly in the Caribbean) who offer super saver rates. We see advertisements in medical magazines touting the "miracle malpractice cure" and premiums of only \$1000 to \$5000 annually. These advertisements tout low rates and affiliations with

What to Look for in an Insurer

Physicians who spend years preparing for their profession should be willing to invest some time in selecting a quality insurer. After all, their reputation is on the line, as well as their assets.

A respected insurer in your state must do three things correctly: (1) Charge a proper premium; (2) administrate their business fairly and professionally; and (3) investigate and dispose of all claims.

Once you are certain these basics are met, you can judge the quality of your insurer by asking questions such as:

- **What is your A. M. Best Rating?** All A ratings are acceptable. Do not settle for anything less.
- **How much physician representation do you have on your board of directors and/or management team?** Look for companies that are truly attuned to the physician's needs, or better yet, a physician controlled company.
- **How much medical expertise do your claims representatives have?** The best companies will have claims personnel who are able to discuss and understand medical standards and tap into the resource of doctors living in the state willing to serve on an internal claims committee.
- **What is your legal record (claims filed, claims won/lost) in my home state?** Being aligned with a prestigious law firm is not enough. Your insurer should have a good knowledge of your state's legal environment and a good track record.
- **What type of risk management services do you offer?** If your insurer does not have an in-house risk management department, this is a warning sign. Look for companies that are truly committed to the control of claims. Some companies have refined risk management to the point that they offer risk assessment evaluations and classes. Often, physicians can earn a credit on their premiums for attending risk management classes.

In addition to asking the above questions, ask to see the company's financial data. You will certainly want to place your premium dollars with a financially strong organization.

prestigious local law firms by saying "our management uses firms like such and such law firm." Note the key word "like" which means they do not necessarily use the prestigious firm mentioned! Enough doctor's checks disappear into the south seas or the Caribbean to justify the comment that not all the pirates on the islands are dead!

Like most great deals, physicians have found that medical malpractice premiums that seem too good to be true, usually are. Realistically, the most expensive insurance a physician can purchase is the "bargain" from an unstable company. All too often, the physician ends up paying the loss not covered by a defunct insurer's insolvency fund. Such insolvency funds generally have limitations such as \$100,000. In the sidebar accompanying this article, I have

detailed some of the things you should look for in a reputable medical malpractice carrier.

Looking ahead — 1993 and beyond

As discussed earlier, claims frequency has fluctuated while claims severity steadily increased. While this is not a happy trend, it **has** been fairly consistent. This consistency has given Kentucky doctors a stable market for medical professional liability insurance.

However, the more recent trends indicate a rise in **both** frequency and severity. If this continues, premiums are likely to start rising again and insurers not fully committed to medical professional liability insurance may decide to get out of the business entirely.

As for the organizational nature of the medical malpractice industry, I expect our nation's many small companies to organize regionally. By the year 2000, I anticipate very few companies will limit their policyholders to a single state. Today's competitive marketplace demands economies of scale and most providers of medical malpractice insurance are certain to seek this simple solution to reducing costs.

Manny Buzzell is a 34-year veteran of the insurance industry. As Vice Chairman of Advanced Risk Management Services for Willis Corroon, he is responsible for designing, developing, and arranging reinsurance for corporations and groups faced with high cost insurance needs.

Memoir of David Arthur Hull 1924-1992

by Richard F. Hench, MD



Dr David Hull died at his home in Lexington, Kentucky, on September 9, 1992. His death ended a long and distinguished career in Kentucky medicine.

He practiced general and vascular surgery in Lexington from 1953 until he was elected Fayette County Coroner in 1989. He served the Kentucky Medical Association as President, Chairman of the Board of Trustees, Trustee, on many committees, and performed numerous other duties. He served as President of the Fayette County Medical Society and was prominent in Lexington medicine throughout his career.

Dr Hull was former Chairman of the Department of Surgery and President of the Medical Staff at Central Baptist Hospital. He served on the staffs of Good Samaritan, St. Joseph, Humana, and the University of Kentucky Hospitals.

He was a member of the American Medical Association, American College of Surgeons, Kentucky Surgical Society, and many other medical organizations.

He was a Navy veteran of World War II.

Dr Hull provided leadership to the Kentucky Medical Association in such

crucial areas as peer review, continuing medical education, and socioeconomic matters. He was instrumental in the founding of the Kentucky Medical Insurance Company and was a member of the first Board of Directors.

Dr Hull was born in Mattoon, Illinois, and attended Westminster College in Fulton, Missouri. He graduated from the University of Tennessee College of Medicine in Memphis, and received his training in surgery at Henry Ford Hospital in Detroit and at the St. Joseph Hospital in Lexington.

He is survived by his wife, Jennie B. Hull; two daughters, Debbie Breeze and Amy Hull; two sons, John David and Cary; a stepson, Brent Bishop; and a sister, Mary Savage. He was a member of the Chapel Hill Presbyterian Church in Lexington.

Dr Hull will be long remembered as a doctor, a husband, a father, a leader, a teacher, a gentleman, and a friend. His achievements and contributions will stand as a monument to his life and as an inspiration to the medical profession in Kentucky.



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Physician Recognition Award Recipients

Listed below are KMA member physicians in Kentucky who have earned the AMA's Physician's Recognition Award (PRA) from July 1991 through June 1992.

The Award was established by the AMA House of Delegates of the American Medical Association in 1968 "to encourage physician participation in continuing medical education and to recognize physicians who have voluntarily completed programs of continuing medical education." A minimum of 150 credit hours of CME must be earned over a consecutive 3-year period to qualify for the Award. Of these 150 hours, at least 60 must be in AMA/PRA Category 1. Ninety hours of education can be in

Abram, Mark A.	Bardstown	Folarin, Victor A.	Madisonville
Amin, Elizabeth A.	Louisville	Foster, Will S.	Louisville
Ante, Jose P.	Louisville	Garcia-Gray, Elizabeth A.	Prospect
Armstrong, Aubrey L.	Greenville	George, Salem M.	Lebanon
Bacon, William G.	Flemingsburg	Goode, Lyndon S.	Hopkinsville
Badrudduja, Syed G.	Prestonsburg	Gould, James R.	Paducah
Baliton, Romeo C.	Leitchfield	Graham, Scott R.	Marion
Bautista, Fe L.	Mt. Washington	Green, Kenneth E.	LaGrange
Beineke, Daniel D.	Maysville	Griffin, Larry P.	Louisville
Binegar, Garry N.	Owensboro	Grogan, Edwin L.	Paducah
Borrone, Elizabeth J.	Lexington	Hagen, Michael D.	Lexington
Bosler, James W.	Louisville	Hager, William D.	Lexington
Briones, Tristan St. E.	Owensboro	Hall, Mary A.	McDowell
Brodsky, Stuart L.	Mayfield	Hall, Maurice M.	Paintsville
Brown, Randall S.	Henderson	Haugh, Robert M.	Paducah
Bunch, Edwin L.	Lexington	Holtzclaw, Russell C.	Somerset
Byrd, Robert D.	Lewisport	Hromyak, George F.	Frankfort
Chandler, Donald W.	Madisonville	Huang, Tsung Y.	Louisville
Chandler, John D.	Benton	Jacobs, Jamie J.	Lexington
Chaney, George R.	Hazard	Johnson, Ronald M.	Owensboro
Chism, Ronald G.	Louisville	Johnson, William M.	Pikeville
Clear, Robert C.	Bellevue	Kakascik, Gerald E.	Paducah
Coffey, David C.	Lakeside Park	Kar, Pran M.	Bowling Green
Cohen, Norman K.	Louisville	Kennedy, Barbara L.	Louisville
Cohen, Stuart P.	Louisville	Kennedy, Lowell D.	Lexington
Cook, William B.	Prestonsburg	Kim, Chun H.	Flatwoods
Cowan, John L.	Louisville	Klompus, William H.	Madisonville
Crum, John E.	Louisville	Knost, James A.	Lexington
Dansby, Karen N.	Ashland	Knox, Robert D.	Louisville
Dempsey, Harry J.	Hopkinsville	Kuebler, Walter J.	Bowling Green
Denton, Clarence E.	Louisville	Kuhn, John E.	Louisville
Dewar, Douglas S.	Whitley City	Lach, John A.	Louisville
Dougherty, Hugh K.	Hopkinsville	Lichtenstein, Philip K.	Highland Heights
Douglas, David W.	London	Lipson, Steve F.	Louisville
Fischer, Karen F.	Murray	Litsey, James F.	Owensboro

Category 2 which includes CME lectures and seminars not designated Category 1; medical teaching; articles, publications, books, and exhibits; and nonsupervised CME such as self-instruction, consultation, patient care review, and self-assessment. Credit hours are based on hour-for-hour participation in a continuing medical education activity with the number of hours rounded to the nearest whole hour.

We congratulate these physicians who have distinguished themselves and their profession by their commitment to continuing education. KMA

Luftman, Martin J.	Lexington	Roeckel, Irene E.	Lexington
Lynn, Dennis A.	Somerset	Rollo, Frank D.	Louisville
Maddox, Tom S.	Owensboro	Rosdeutscher, Harold D.	Bowling Green
Maddux, Howard G.	Marion	Sadtler, Joseph E.	Louisville
Mahl, Charles F.	Louisville	Sander, Mark D.	Florence
Manion, Maria E.	Louisville	Sandoval, Armando C.	Henderson
Maya, Gaston N.	Louisville	Schrand, James R.	Florence
McClellan, John W.	Henderson	Shafii, Mohammad	Prospect
McEndre, Roy B.	Lewisburg	Sharp, Richard B.	Louisville
McHenry, Ross	Covington	Shearer, David A.	Florence
Melton, Gary J.	Dry Ridge	Shipp, Charles J.	Greenville
Molloy, James F.	Louisville	Shively, Eugene H.	Campbellsville
Moore, Charles C.	Middlesboro	Sills, James G.	Hardinsburg
Moore, Thomas L.	Crestwood	Slabaugh, Thomas K.	Lexington
Mukherjee, Sudhideb	Georgetown	Smith, Paul R.	London
Nelson, Erik G.	Lakeside Park	Smith, Richard F.	Lexington
Nethers, Michael S.	Louisville	Spanos, William J.	Louisville
Noble, James B.	Beattyville	Swift, James F.	Louisville
Oliver, Earl P.	Scottsville	Travis, Russell L.	Lexington
Oropilla, Teresita B.	Louisville	Van Hoose, James E.	Paintsville
Orrahood, M. David	Owensboro	Van Meter, Woodford S.	Lexington
Paris, Allan	Louisville	Vannier, Frank P.	Louisville
Patterson, James H.	Lexington	Wahl, Robert R.	Louisville
Periyanayagam, Srinivasan	Madisonville	Waller, William M.	Walton
Perkins, Don L.	Hopkinsville	Weitzel, William D.	Lexington
Petit, James M.	Ft. Thomas	Wells, Henry A.	Covington
Podruch, Philip E.	Louisville	Wiesemann, Richard J.	Bowling Green
Pollard, Stephen J.	Louisville	Wilson, Larry J.	Louisville
Rand, Bernard O.	Louisville	Wolf, Paul A.	Okolona
Reams, Gerald B.	Ashland	Wolf, Richard S.	St. Matthews
Reynolds, Jeffrey L.	Louisville	Wood, Emmett W.	Bardstown
Rieser, James S.	Louisville	Yaes, Robert J.	Lexington
Rightmyer, Gerald R.	Henderson	Young, Nguyen T.	Elizabethtown
Robbins, Robert E.	Elizabethtown	Yunker, Phillip H.	Maysville
Rodriquez, Jose L.	Ashland	Zax, Robert H.	Louisville

1992 KMA Annual Meeting Highlights

The 142nd meeting of the Kentucky Medical Association concluded September 17, 1992. During the Annual Meeting, 23 specialty groups held sessions and the House of Delegates convened on two occasions. The President's Luncheon featured the installation of Northern Kentucky urologist William B. Monnig, MD, as the 142nd President of KMA. Attendees also honored outgoing President S. Randolph Scheen, MD.

The Luncheon also featured the presentation of the Distinguished Service Award to KMA Past President James B. Holloway, Jr, MD, a retired Lexington general surgeon and present Medical Director of Kentucky's Medicare Program.

Listed below are the highlights of actions taken by the House of Delegates. Readers are reminded that only a brief summary of Committee actions or Resolutions enacted are included: We refer you to the December 1992 issue of the *Journal of the Kentucky Medical Association* where text of the Committee reports and Resolutions are printed in full.

- Called on the Kentucky Board of Medical Licensure to require participation by physicians in continuing medical education as a condition of licensure. The participation in required CME consists of the acquisition of 60 hours within a three-year period.
- Recommended KMA support the joint collaborative practice of physicians and ARNPs; endorse legislation to permit ARNPs to prescribe under written protocol and formulary approved by the supervising physician and appropriate licensing authorities; require that ARNPs complete established pharmacological prerequisites and maintain continuing education in the use of prescribed substances in chosen

specialties; support the concept that there should be well-defined limits on the number of ARNPs any physician may supervise within closely defined geographic areas; and establish safeguards through legislation to prohibit independent and unsupervised practice.

- The House of Delegates revised KMA's position on Certificate of Need. Private offices and clinics of physicians and other practitioners of the healing arts should be exempt from CON requirements, including but not limited to licensure, supervision, regulation, or control regulated by the Commission on Health Economics Control, *except as they propose to provide equipment which costs exceed \$250,000, with adjustments for inflation.*
- Reaffirmed its policy regarding coordination of state legislative activities. All state legislative proposals are to be coordinated by and channeled through the Committee on State Legislative Activities. Retain composition, function, and authority of Quick Action Committee. The composition, priority, manner, and time of introduction of state legislative proposals are to be left to the discretion of the Chairman of the Committee on State Legislative Activities and the Quick Action Committee.
- Designated the officers and Board of Trustees to serve the organization in all negotiations associated with development and implementation of health care reform considered by the 1992 special session of the Kentucky State Legislature called by Governor Brereton Jones.
- Adopted the current edition of Davis' *Rules of Order* as the parliamentary guide for all deliberations.
- Directed KMA to consult heavy volume providers of mammography

screenings to seek out level of costs and expenses and requested KMA to get a list of current contracts from the Department for Health Services of counties that are currently providing mammograms. In addition, KMA should publicize that there is a mammography screening program for indigent women available, as well as a subsidy for this program through SB 41 of the 1990 General Assembly.

- Encouraged the Kentucky General Assembly to increase its attention to the serious health problems related to tobacco products, as well as encouraging physicians to intensify educational efforts directed to patients on the deleterious effects of tobacco use.
- Urged the KMA to work with specialty societies, state medical schools, and individual members to coordinate preceptorships for medical students in private practice primary care settings and have training episodes begin prior to the third year of medical school study.
- Directed KMA to encourage the Kentucky Cabinet for Human Resources to survey out-of-state physicians trained in Kentucky to determine factors contributing to their decisions to leave the state and share with appropriate organizations, if such information is not currently available.
- Directed KMA to work with medical schools to have 50% of their graduates enter primary care programs, and insure that 40% of graduates enter the practice of primary care medicine, and enlist aid of other appropriate agencies and organizations in this effort. Also requested KMA to actively encourage and support the strengthening of existing family practice residency programs in the state with regard to funding, faculty,

and clinical experience.

- Encouraged the Impaired Physicians Committee to explore the possibility of including in its program physically handicapped physicians and their need for alternative career choices.
- Opposed any legislative proposals that institute an involuntary service requirement for physicians trained in Kentucky.
- Urged the KMA to work with the Kentucky General Assembly to increase the excise tax on the sale of cigarettes.
- Direct KMA to work with the Kentucky Board of Education to include in the curriculum appropriate information for teachers to educate their students about the hazards of ultraviolet radiation and tanning parlors.
- Expressed sincere thanks and appreciation to S. Randolph Scheen, MD, for his exemplary service and devotion to the KMA for more than 25 years.
- Directed KMA to further educate

physicians on recognizing symptoms of domestic/interpersonal violence. Urge all county medical societies to work with local committees to educate communities on the serious issue of domestic/interpersonal violence.

- Encouraged medical schools to create mentor groups with professors, residents, and medical students to discuss the benefits of membership to the KMA.
- Recommended that all high-risk newborns covered by Medicaid be followed by their physicians and their designates to insure PKU testing, infant immunizations, access to the WIC program, preventive care, and repeat pregnancy education. The importance of preventive health measures including immunizations, is recognized for all infants and children in the Commonwealth.
- Recommended KMA pursue a separate committee to study infant mortality and fetal death.
- Encourage the Legislature to enact

restrictions on smoking in the next and subsequent sessions of the Kentucky General Assembly, including an indoor air standard, a ban on smoking from all school buildings and school-sponsored events, a ban on sale of tobacco products in vending machines except in areas off-limits to minors, use tobacco knowledge for criteria under framework of education reform, ban tobacco company sponsorship of youth athletic events, require a retailer selling tobacco products to have a license, ban distributions of free tobacco product samples, restrict tobacco advertising to black-and-white printed text without pictures, and repeal "smokers rights" provisions.

• Seek administrative and legislative commitment to amend the Kentucky Education Reform Act (KERA) to require schools (grades K-12) to include health education in the curriculum.

KMA

Board of Trustees Fall Meeting

Acting as temporary Chairman, KMA Secretary-Treasurer William P. VonderHaar, MD, introduced the newly elected members of the Board and the new officers: Ardis D. Hoven, MD, Lexington, President-Elect; David C. Liebschutz, MD, Danville, Vice President; Harry W. Carlross, MD, Paducah, Trustee, 1st District; William H. Klompus, MD, Madisonville, Trustee, 3rd District; Salem M. George, MD, Lebanon, Trustee, 4th District; Scott B. Scutchfield, MD, Danville, Trustee, 12th District; and E. D. Roberts, MD, Pikeville, Trustee, 14th District.

The Board elected the Executive Committee members to serve with the President, President-Elect, Vice President, and Secretary-Treasurer for the 1992-93 KMA year. Russell L. Travis, MD, Lexington, was reelected Chairman of the Board, and John W. McClellan, MD, Henderson, was elected Vice Chairman. William H. Mitchell, MD, Richmond, and Don R. Stephens, MD, Cynthiana, were named as Trustees-at-Large.

It was noted that the KMA Executive Committee members also serve as the Boards of Directors of KMA Physicians Services, Inc (KMA's

holding company), and the KMA Building Corporation.

The Board also made changes to the Kentucky Foundation for Medical Care Board of Directors in accordance with KFMC's Bylaws, and appointed KMA committees for the following year. The next meeting of the KMA Board of Trustees is scheduled for December 16-17, 1992, at the Hyatt Regency Hotel in Louisville.

KMA

PEOPLE


Stephen B. Kelley, MD, Somerset, was recipient of an alumni achievement award during the Ohio State University College of Medicine Alumni Reunion. Alumni achievement awards recognize graduates of the College of Medicine who have excelled or made important contributions in their fields.

Dr Kelley has practiced in Somerset since 1963 and is a member of an eight-person primary care group composed of family practice and internal medicine physicians.

He was named Citizen's Doctor of the Year in 1978 by the Kentucky Academy of Family Physicians and elected president of the academy in 1980. He is vice president for the Southeast Region of Boy Scouts of America and heavily involved in local and state civic affairs.

Clyde M. Brassfield, MD, was among a group from Hardin Memorial Hospital recently recognized for health care innovation by the National Awards Program of the American College of Physician Executives. The program recognizes exceptional work done by health care professionals who have made

advances in improving the quality of health care or who have made advances in improving the management of health care costs.

The innovation being honored, Cooperative Effort Brings Obstetric Services to Needy Population, is a result of the creation of the Obstetrical Care Clinic to serve women in the Lincoln Trail District of Central Kentucky.

UPDATES
UK Researchers Receive NIA Program Project Grant

A University of Kentucky research team has received a 5-year program project grant of approximately \$4 million from the National Institute on Aging (NIA) to study the role of calcium regulation in brain cells during aging and Alzheimer's disease.

The UK study will examine how age-related changes in the body's own physiology may affect levels of calcium within cells. The research's focus is the hypothesis that gradual deregulation of calcium in nerve cells that occurs with aging can lead to a degeneration of the central nervous system. In Alzheimer's disease, this degeneration is rapidly accelerated and results in the loss of memory, communication and motor skills, and the ability to reason. The premise is particularly promising in that it offers a possible explanation of why Alzheimer's disease increases exponentially after age 60 and is seen in almost 50% of people age 85 and older.

The multidisciplinary team of more than 20 researchers includes faculty members from the College of Medicine's department of pharmacology, biochemistry, diagnostic radiology, neurology, medicine, anatomy and neurobiology,

microbiology and immunology, and pathology, the UK Sanders-Brown Center on Aging, and the department of chemistry. The department of statistics will play a key role in experimental design and data analysis.

KMA member and professor of medicine, **Dr Hartmut Malluche**, will lead a research team to determine the role of calcium regulatory hormones and serum calcium/phosphate regulation in the origin and progression of Alzheimer's disease.

"This research undertaking may help to unravel the mysteries of Alzheimer's disease," said **Dr Emery A. Wilson**, dean of the UK College of Medicine.

Alzheimer's Disease Resources

In December 1991 the Alzheimer's Association officially dedicated the Benjamin B. Green-Field National Alzheimer's Library and Resource Center. This facility provides a centralized location for research materials, educational publications, and print and nonprint materials related to Alzheimer's disease. Materials are collected both for medical professionals and laypeople.

The Resource Center's mission is to help increase knowledge of the medical, clinical, and social aspects of Alzheimer's disease and related disorders. The center is a source of information for those involved in patient care, policy development, research, or those who simply want to know more about the disease.

Information requests may be made in person, by telephone, or by mail. The public may use materials in the library or borrow materials via interlibrary loan through their public or institutional library. The library will use compact disk technology to provide access to articles written in general and scientific periodicals. Descriptions of materials in the collection are stored in a computer

database rather than a card catalog. Direct access to the database is available by using a microcomputer with a modem and appropriate software.

For additional information please contact Patricia Pinkowski, Director, Benjamin B. Green-Field National Alzheimer's Library and Resource Center, 919 N Michigan Ave, Suite 1000, Chicago, IL 60611-1676, phone 312/335-9602; Fax: 312/335-0214.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Fayette

Charles G. Grigsby, Jr MD — IM
114 Stone Road, Lexington 40503
1985, U of Kentucky

Charles C. Johnson, DO — FP
1221 S Broadway, Lexington 40504
1988, Michigan State U Col of Osteopathic Medicine

Valerie T. Mandina, MD — PTH
1221 S Broadway, Lexington 40504
1984, Louisiana State University

Sharon D. Menkus, MD — PD
2620 Wilhite Drive, Lexington 40503
1989, U of Pittsburgh

Monty S. Metcalfe, MD — HEM
3080 Harrodsburg Rd #200
Lexington 40504
1978, U of Kentucky

Randall L. Updegrove, MD — PM
1221 S Broadway, Lexington 40505
1983, Brown U

Mary Jean Vogt, MD — IM
1221 S Broadway, Lexington 40504
1987, U of Kentucky

Jonathan C. Waltman, MD — C
1401 Harrodsburg Rd
Lexington 40504
1986, Cornell U

David A. Wyatt, MD — TS
UKMC — Rm 273MN, Lexington 40536
1983, U of South Alabama

Floyd

Mohammed K. Ashraf, MD — IM
P O Box 265, McDowell 41647
1980, Dacca Medical College, Bangladesh

Green

William D. Feltner, DO — GP
122 Circle Dr, Greensburg 42743
1989, Kirksville College of Osteopathy

Hardin

Joel C. Sim, MD — R
121 Durbin Way, Vine Grove 40175
1964, Far Eastern U, Philippines

Lawrence

Michael Z. Arbel, MD — PD
302 Third St, Louisa 41230
1984, Israel Institute of Technology

Madison

Hameed I. Koury, MD — S
789 Eastern Bypass #23,
Richmond 40475

1987, U of Kentucky
John E. Miller, MD — OPH
238 Geri Lane, Richmond 40475
1988, U of Kentucky

Northern Kentucky

James J. Roebker, MD — R
170 Barnwood Dr, Edgewood 41017
1987, U of Kentucky

Pike

Bapuki Narra, MD — R
235 Chloe Rd, Pikeville 41501
1973, Kakatiya Medical College, India

Warren

Mark J. Bucksbaum, MD — PMR
1300 Campbell Lane
Bowling Green 42104

1984, St. George's U, West Indies
Timothy A. Wierson, MD — S
201 Park St, Bowling Green 42101
1987, U of Iowa

In-Training

Fayette

Gregory W. Briscoe, MD — P
Felicia A. Farris, MD — FP
Narayanacher S. Muralai, MD — IM
John T. Trump, MD — ORS

Northern Kentucky

Gregory A. Niehauser, DO — FP

DEATHS

David A. Hull, MD
Lexington
1924-1992

David A. Hull, MD, a retired surgeon, died September 9, 1992. Dr Hull served as KMA President from 1975 to 1976. He graduated from the University of Tennessee College of Medicine in 1947 and was a life member of KMA. (See article on page 573.)

Laman A. Gray, Sr, MD
Louisville
1908-1992

Laman A. Gray, Sr, MD, a retired obstetrician, died September 19, 1992. Dr Gray was one of the founders of the J. Graham Brown Regional Cancer Center and president of the Regional Cancer Center Corporation, the non-profit organization that funded the Center's construction in 1981. During his career, Dr Gray was awarded a distinguished Alumni Award from Arkansas College, a Service Award from U of L, and distinguished-service awards from the American Cancer Society and the Kentucky Medical Association. He was also a founding member of the board of managers of the Ephraim McDowell House in Danville. Dr Gray graduated from John Hopkins University School of Medicine and was a life member of KMA.

PHARMACEUTICALS AVAILABLE TO KENTUCKY PHYSICIANS CARE

These Pfizer/Roerig/Pratt & Searle pharmaceuticals may be prescribed and dispensed under the program:

Pfizer Labs

Antiminth® (Pyrantel pamoate) OTC
Cartril® Topical Ointment 1% (Hydrocortisone) Rx
Diabinese® Tablets (Chlorpropamide) Rx
Diabinese® Tablets Unit-Dose Pak (Chlorpropamide) Rx
Feldene® Capsules (Piraxicam) Rx
Feldene® Capsules Unit-Dose Pak (Piraxicam) Rx
Minipress® Capsules (Prazosin HCl) Rx
Minipress® Capsules Unit-Dose Pak (Prazosin) Rx
Minizide® 1 Capsules (1 mg. Prazosin and 0.5 mg. Palythiazide) Rx
Minizide® 2 Capsules (2 mg. Prazosin and 0.5 mg. Palythiazide) Rx
Minizide® 5 Capsules (5 mg. Prazosin and 0.5 mg. Palythiazide) Rx
Maderil® Tablets (Rescinamine) Rx
Narvasc® (2.5, 5 and 10 mg.) Rx
Renese® Tablets (Palythiazide) Rx
Renese®-R Tablets (2 mg. Palythiazide and 0.25 mg. Reserpine) Rx
Sustaire® (Theophylline anhydrous) Rx

Terramycin® Capsules (Oxytetracycline HCl) Rx
Vansil® Capsules (Oxamniquine) Rx
Vibra-Tabs® (Doxycycline hyclate) Rx
Vibra-Tabs® Unit-Dose Pak (Doxycycline hyclate) Rx
Vibramycin® Calcium Syrup (Doxycycline calcium oral suspension) Rx
Vibramycin® Hyclate Capsules (Doxycycline hyclate) Rx
Vibramycin® Hyclate Capsules Unit-Dose Pak (Doxycycline hyclate) Rx
Vibramycin® Manahydrate for Oral Suspension (Doxycycline manahydrate) Rx
Vistaril® Capsules (Hydroxyzine pamoate) Rx
Vistaril® Capsules Unit-Dose Pak (Hydroxyzine pamoate) Rx
Vistaril® Oral Suspension (Hydroxyzine pamoate) Rx
Zithramax® Capsules (Azithromycin)

Roerig

Antivert® (Meclizine HCl) Rx
Antivert® Tablets Unit-Dose Pak (Meclizine HCl) Rx
Atarax® (Hydroxyzine HCl) Rx
Atarax® Tablets Unit-Dose Pak (Hydroxyzine HCl) Rx
Banine® Chewable Tablets (Meclizine HCl) OTC
Cardura® Tablets (Doxazosin Mesylate) Rx
Cefabid® (Cefaperazone sodium) Rx
Diflucan® (Fluconazole) Oral and Parenteral Antifungal Rx
Diflucan® (Fluconazole) Unit-Dose Pak Oral and Parenteral Antifungal Rx
Emete-can® IM/IV (Benzquinamide HCl) Rx
Geocillin® (Carbenicillin indanyl sodium) equivalent to 382 mg. carbenicillin Rx
Geopen IM/IV (Carbenicillin disodium) Rx
Heptuna® Plus Capsules (Iron plus vitamins and minerals) Rx
Hydrocortisone Powder (Hydrocortisone USP micronized) Rx
Isaject® Permapen® (Penicillin G benzathine) Aqueous Suspension Rx
Marax® (Hydroxyzine HCl [ATARAX®]-Theophylline-ephedrine sulfate) Rx
Navane® Capsules (Thiathixene) Rx
Navane® Capsules Unit-Dose Pak (Thiathixene) Rx
Navane® Concentrate (Thiathixene HCl) Rx
Navane® Intramuscular (Thiathixene HCl) Rx
Pfizerpen® for Injection (Penicillin G potassium) Buffered Rx

Pfizerpen®-AS (Penicillin G procaine) Aqueous Suspension Rx
Palmyxin B Sulfate Sterile Rx
Sinequan® Capsules (Doxepin HCl) Rx
Sinequan® Capsules Unit-Dose Pak (Doxepin HCl) Rx
Sinequan® Capsules Unit of Use Pak (Doxepin HCl) Rx
Sinequan® Oral Concentrate (Doxepin HCl) Rx
Spectrabid® Oral Suspension (Bacampicillin HCl) Rx
Spectrabid® Tablets (Bacampicillin HCl) Rx
Streptomycin Sulfate Rx
Taa® Capsules (Troleandomycin) Rx
Terra-Cartril® Ophthalmic Suspension (Oxytetracycline HCl and hydrocortisone acetate) Rx
Terramycin® Intramuscular Solution (Oxytetracycline) Rx
Terramycin® Ophthalmic Ointment with Palmyxin B Sulfate (Oxytetracycline HCl with palmyxin B sulfate) Rx
Terramycin® Vaginal Tablets with Palmyxin B Sulfate (Oxytetracycline HCl with palmyxin B sulfate) Rx
Unasyn® (Ampicillin sodium/sulbactam sodium) Rx
Urabiotic® 250 (250 mg. Oxytetracycline HCl 250 mg. sulfamethizole 50 mg. phenazopyridine HCl) Rx
Vibramycin® Intravenous (Doxycycline hyclate for injection) Rx
Vistaril® Intramuscular Solution (Hydroxyzine HCl) Rx
Vistaril® Intramuscular Solution Unit-Dose Vials (Hydroxyzine HCl) Rx
Zalaff® Tablets (Sertraline) Rx

Pratt Division

Glucotrol® Tablets (Glipizide) Rx
Glucotrol® Tablets Unit-Dose Pak (Glipizide) Rx
Feldene® Capsules (Piraxicam) Rx
Feldene® Capsules Unit-Dose Pak (Piraxicam) Rx
Pracardia® Capsules (Nifedipine) Rx

Pracardia® Capsules Unit Dose Pak (Nifedipine) Rx
Pracardia XL® (Nifedipine) Extended Release Tablets Rx
Pracardia XL® (Nifedipine) Extended Release Tablets Unit-Dose Pak Rx
Zalaff® Tablets (Sertraline) Rx

Searle

Aldactazide® tablets (spironolactone with hydrochlorothiazide)
Aldactone® tablets (spironolactone)
Calan® SR caplets (verapamil HCl)
Calan® caplets (verapamil HCl)
Cytotec® tablets (misoprostol)

Kerlane® tablets (betaxalol HCl)
Nitradisc® discs (nitroglycerin)
Narpac® capsules (disopyramide phosphate)
Narpac® CR capsules (disopyramide phosphate)

PHARMACEUTICALS AVAILABLE TO KENTUCKY PHYSICIANS CARE

These Johnson & Johnson pharmaceuticals may be prescribed and dispensed under the program:

Iolab Corporation

Argyrol® S.S. (mild silver protein)
Atrapisal® Ophthalmic Solution (atropine sulfate)
Cotarose® (chymotrypsin)
Dexocidin® Ophthalmic Suspension and Ointment (dexamethasone, neomycin and polymyxin B sulfates)
Dexamethasone Sodium Phosphate Ophthalmic Solution 0.1%
Dexamethasone Sodium Phosphate 4 mg/ml (for injection)
Epinephrine
E-PILO® Ophthalmic Solution (epinephrine bitortate-pilocarpine HCl)
Eserine Sulfate Sterile Ophthalmic Solution
Fluorescein Sodium
Fluor-Op® Ophthalmic Suspension (fluorometholone .1%)
Funduscein® -10, -25 Injection (fluorescein sodium)
Gentocidin® Solution and Ointment (gentamicin sulfate)
Gentomicin 40 mg/ml, 80 mg/2 ml (for injection)
Glucose-40 Sterile Ophthalmic Ointment
Homotropine Hydrobromide
Inflamase® Forte Ophthalmic Solution (prednisolone sodium phosphate)

Inflamase® Mild Ophthalmic Solution (prednisolone sodium phosphate)
Iocore® Balanced Salt Solution
Miachol® Introocular & System Pak (acetylcholine chloride)
Neomycin, Polymyxin B sulfates, and Hydrocortisone Ophthalmic Suspension
Neomycin, Polymyxin B sulfates, and Gramidicin Ophthalmic Solution
Neomycin Sulfate/Dexamethasone Sodium Phosphate Ophthalmic Solution
Phenylephrine HCl 10%/2.5%
Pilocor® Ophthalmic Solution (pilocarpine HCl)
Sulf-10® Ophthalmic Solution (sodium sulfacetamide)
Tetracone HCl
Vosocidin® Ophthalmic Solution (sulfacetamide sodium-prednisolone sodium phosphate) & Ointment (sulfacetamide sodium-prednisolone acetate)
Vosacan-A Ophthalmic Solution (naphazoline HCl-antazoline phosphate)
Voscon Regular Ophthalmic Solution (naphazoline HCl 0.1%)
Vososulf® Ophthalmic Solution (sulfacetamide sodium-phenylephrine HCl)

Janssen Pharmaceutica, Inc.

*Durogesic® Transdermal system (fentanyl)
Ergomisol® Tablets (levamisole HCl)
Hismonol® Tablets (ostemizole)
Imodium® Capsules (loperamide HCl)

Nizoral® Cream (ketacanazole)
Nizoral® Shampoo (ketacanazole)
Nizoral® Tablets (ketacanazole)
Vermox® Tablets (mebendazole)

McNeil Consumer Products Company

Chemet® Capsules (succimer)

PediprafenTM Suspension (ibuprofen)

McNeil Pharmaceutical

Flaxin® Tablets (ofloxacin)
Haldal® Tablets and Concentrate (haloperidol)
Haldol® Deconote Injection (haloperidol)
Pancrease® Capsules (pancrelipase)
Pancrease® MT Capsules (pancrelipase)
Poroflex® Coplets (chlorzoxazone)

Porafan Forte® DSC Coplets (chlorzoxazone)
Talectin® Capsules and Tablets (talmetin sodium)
Tylenol® with Codeine Tablets and Elixir (acetaminophen and codeine phosphate)
*Tylox® Capsules (oxycodone hydrochloride and acetaminophen capsules USP)
Vascar® Tablets (bepridil HCl)

Ortho Biotech

Procrit® Injection (epoetin Alfa)

Ortho Pharmaceutical Corporation

Aci-Jel® Therapeutic Vaginal Jelly
Floxin® Tablets (ofloxacin)
Micronor® Tablets (norethindrone)
Madicon® Tablets (norethindrone/ethinyl estradiol)
Ortha® Dienestrol cream (dienestrol)
Ortha-Novum® Tablets (norethindrone/mestranol) or (norethindrone/ethinyl estradiol)
Protostat® Tablets (metronidazole)
Sultrin® Triple Sulfo Cream and Vaginal Tablets (sulfathiazole/sulfacetamide/sulfobenzamide)

Terozol® Cream and Vaginal Suppositories (tercanazole)
Erycette® Topical Solution (erythramycin)
Grifulvin V® Tablets/suspension (griseofulvin microsize)
Meclon® Cream (meclocycline sulfosuccinate)
Monistat Derm® Cream (miconazole nitrate)
Perso-Gel® & Perso-Gel® W (benzoyl peroxide)
Retin-A® Cream/Gel/Liquid (tretinoin)
Spectazole® Cream (econazole nitrate)

*Duragesic® and Tylox® (CII controlled substances) will be replaced with other products.

PARTICIPATING PHARMACIES KPC PHARMACY PROVIDER PROGRAM

Adair
DBA Columbia Pharmacy
Madison Square Drugs & Chymist

Allen
Carpenter Dent Drugs
Stavall Prescription Shop
Williams Pharmacy

Anderson
The Medicine Shoppe
Reliable Drugs

Ballard
Wickliffe Pharmacy, Inc

Borren
Ely Drugs, Inc
Glasgow Prescription Center
K-Mart Pharmacy
Tawne & Cauntry Drugs

Bell
City & Cauntry Drug
Farris Drugs
Jeff's Pharmacy
K-Mart Pharmacy
Kramer Company
Pineville Has. Out-Pt Pharmacy
Rxca Friendly Pharmacy
SuperX Drugs
Total & Care Pharmacy

Boone
Boone Cauntry Drugs
Burlington Pharmacy
K-Mart Pharmacy
SuperX Drugs
Turkway Pharmacy

Bourban
Glen's Drugs
Harne's Ardrey Drug
The Medicine Shoppe

Boyd
K-Mart Pharmacy
Laynes Pharmacy
McMeans Pharmacy
Reliable Drugs
SuperX Drugs

Boyle
Grider Pharmacy
K-Mart Pharmacy
Leake Pharmacy
SuperX Drugs
Taylor Drug

Brocken
Dean's Pharmacy

Breathitt
Jackson Prescription Ctr
Reliable Drugs

Breckinridge
Save-Rite Drugs
Tawne & Cauntry Pharmacy

Bullitt
Taylor Drugs

Coldwell
Payless Discount Pharmacy
The Pharmacy Carner Enterprise

Collaway
Clinic Pharmacy
Halland Drugs
Reliable Drugs
Safe-T Discount Pharmacy
Walter's Pharmacy

Campbell
Alexandria Drugs
Martin's Pharmacy
Newport Drug Center
SuperX Drugs

Carlisle
Arlington Pharmacy, Inc

Carrall
Parklane Pharmacy
Webster Drugs

Carter
Hartan Brather & Brawn
K-Mart Pharmacy
Rose Pharmacy

Christion
Express Pharmacy
Harn Prescription Shop
Jennie Stuart Medical Center
Reliable Drugs
Save Mare Drug
The Medicine Shoppe

Clark
Carner Drug Store
Day Drugs
K-Mart Pharmacy
Reliable Drugs
SuperX Drugs

Clay
Family Drug Center
H & N Drug
Medi Center Drugs

Crittenden
Glenn's Apothecary

Cumberland
Smith Pharmacy

Daviess
Danhauer Drug Company
Emery Centre Pharmacy
Greene's Pharmacy
Harreld's Drug Store
Mayfair Pharmacy
Medical Plaza Pharmacy
Medicine Shoppe
Nation's Medicines
Reliable Drugs
Taylor Drug #21
Wal-Mart Pharmacy
Whitesville Drug Store

Edmanson
Prescription Shop

Foyette
Hi-Acres Pharmacy
Hubbard & Curry Pharmacy
Hutchinsan Drug
K-Mart Pharmacy
All Krager Pharmacies
Professional Arts Apatheary
Randall's Pharmacy
Taylor Drugs
The Medicine Shoppe
Warehouse Drugs
Woodhill Pharmacy

Fleming
Plaza Pharmacy

Floyd
Archer Clinic Pharmacy
Betsy Layne Pharmacy
Brooks Pharmacy, Inc
Mud Creek Clinic Pharmacy
Our Lady Of The Way Hospital

Franklin
East Side Pharmacy
Fitzgerald Drugs
K-Mart Pharmacy
Kramer Pharmacy
Medicine Shoppe
Reliable Drugs
Taylor Drugs
The Prescription Center

Fulton
City Super Drug
Evans Drug Company
Rumfelt Drug
SuperX Drugs

Gorrod
Suttan Pharmacy

Grant
Grant Cauntry Drugs

Graves
K-Mart Pharmacy
Stanes Drugs
SuperX Drugs
Wilson Rexall Drugs

Graysan
Clarksan Drug Store
Reliable Drugs

Green
Model Drug Store

Greenup
Reliable Drugs
Scatt Drugs
Stultz Pharmacy

Hardin
Jeff's Prescription Shop
K-Mart Pharmacy
Kramer Company
Lincoln Trail Pharmacy
Raddiff Drugs
Showers & Hays Drugs
SuperX Drugs
Taylor Drugs
Woolridge Drug

Harlan
Lynch Med. Services Pharmacy
SuperX Drugs

Harrison
Eastside Pharmacy Of Cynthia
Lee Drugs

Hort
Branstetter Pharmacy
Clarks
Mallory Drugs

Henderson
Dunaway's Imperial Pharmacy
K-Mart Pharmacy
Reliable Drugs
T & T Drugs

Henry
Cook's Pharmacy

Hickman
Perkins Pharmacy

Hopkins
Earlington Pharmacy
Family Drugs
Madisonville Pharmacy
Nation's Medicines
Professional Drugs #2
Reliable Drugs
SuperX Drugs

Jackson
Annville Pharmacy
Clinic Pharmacy

Jefferson
Alliant Health System Pharmacy
Applied Pharmacy Therapeutics
Art Jacob Prescription Shoppe
Band Pharmacy
Calanial Drugs
Cax's Pharmacy
Cax's Pharmacy #1
DBA Hametek Pharmacy
Harding Pharmacy
Haldaway Drugs
Hume Pharmacy
K-Mart Pharmacy
Kaby Drug Company
All Krager Pharmacies
Oak Drug Company, #1
Parrina Pharmacy
Rauben's Pharmacy
St. Denis All Care
All SuperX Drugs
All Taylor Drugs
Union Prescription Center
Wal-Mart Pharmacies
Warehouse Drugs

Jessamine
Drug Mart
Medicine Shoppe
Taylor Drugs

Johnson
Bi-Rite Pharmacy
Reliable Drugs

PARTICIPATING PHARMACIES

KPC PHARMACY PROVIDER PROGRAM

Kenton

Blank's Pharmacy
Boeckley Drugs
Cherokee Drug Shoppe
Crestville Drugs
Farrell Pharmacy
Fort Mitchell Drug Shoppe
Fart Mitchell Pharmacy
K-Mart Pharmacy
Ludlow Drugs
Medical Village Pharmacy
Marwessel Drugs
Nie's Independence Pharmacy
Save Discount Drugs
All SuperX Drugs

Knott

East KY Health Services Center

Knox

Knox Professional Pharmacy
Sav-Rite Pharmacy

Laurel

Family Drugs
Kelley's Medical Arts Pharmacy
Laurel Heights Nursing Home
Landon City Drug Co.
Landon-Carbin Pharmacy
SuperX Drugs

Lee

Stufflebean Pharmacy
Three Farks Apothecary

Letcher

Parkway Pharmacy
Shapwise Pharmacy

Lewis

Osman Pharmacy, Inc

Lincoln

Coleman's Drug Store
Rishie Drugs

Livingston

Glenn's Prescription Center

Logan

Gawer Drug Store
Riley-White Drugs
Wal-Mart Pharmacy

Madison

Berea Hospital Out-Patient
K-Mart Pharmacy
Kroger Company
SuperX Drugs

Magoffin

Clinic Pharmacy

Marion

Hagan-O'Daniel Pharmacy
Pat's Pharmacy
Reliable Drugs
Sauthall Pharmacy

Marshall

Benton Discount Pharmacy
Draffenville Pharmacy
J & R Pharmacy
Nelson ValuRite Pharmacy
Pay-N-Save Discount Drugs

Martin

Blacklog Apothecary

Mason

K-Mart Pharmacy
Medical Arts Pharmacy
Reliable Drugs
Toncray Mortar & Pestle

McCracken

Davis Drugs
K-Mart Pharmacy
Katterjohn Drug Store
Kroger
SuperX Drugs
The Medicine Shoppe

McCreary

Burgess Drug Store
Daugherty Drugs

Meade

Riverview Pharmacy

Mercer

Kroger Company
SuperX Drugs

Metcalfe

Metcalfe Drugs
Nunn Drugs

Montgomery

Calica & Whitt Drug
Emil W. Baker, Pharmacist
Rass Drugs
SuperX Drugs

Muhlenberg

Beechmont Pharmacy
Clinic Pharmacy
Reliable Drugs

Nelson

Reliable Drugs

Nicholas

Carlisle Drug

Ohio

L. L. Bane Pharmacy
Reliable Drugs

Rice Drug Store

Oldham

Taylor Drugs

Owsley

Owsley Prescription Center

Pendleton

Mareland Drug

Perry

L. B. Clinic Pharmacy
Reliable Drugs
SuperX Drugs
Vicca Pharmacy

Pike

K-Mart Pharmacy
Medical Pharmacy
Nichals Apothecary
SuperX Drugs

Pulaski

Brown's Bagle Street Pharmacy
K-Mart Pharmacy
Kroger Company
Pharmatech International
Reliable Drugs
Somerset Pharmacy
SuperX Drugs
The Medicine Shoppe
Tibbals Drug Store
Wal-Mart Pharmacy

Rockcastle

Mt. Vernal Drive-Thru
Youngs Pharmacy

Rowan

Cave Run Pharmacy
Marehead Clinic Pharmacy
Reliable Drugs

Russell

Daugherty Pharmacy
Happer Drug
K-Mart Pharmacy
Smith Drug

Scott

Doctor's Park Pharmacy
Fitch Drug Store
K-Mart Pharmacy
Kroger Company
Reliable Drugs

Shelby

Reliable Drugs
Smith-McKenney

Simpson

Arnold Drug Company
Prescription Shop

R. H. Moore Drug Company
Reliable Drugs
Shugart & Willis

Spencer

W. T. Framan Drug Company

Taylor

Central Drug Center
K-Mart Pharmacy
Kroger Company
SuperX Drugs
The Medicine Shoppe

Todd

Weathers Drugs

Trigg

Save On Drugs

Union

Clements Drug
Carner Drug Store
Professional Drugs #1
Reliable Drugs
Sturgis Pharmacy

Warren

Ashley Circle Pharmacy
C. D. S. #10 Drug
Clinic Pharmacy
K-Mart Pharmacy
Medicine Shoppe
Northgate Pharmacy
Reliable Drugs
SuperX Drugs
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*The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control. A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food.

†Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

‡Verapamil should be administered cautiously to patients with impaired renal function.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents.

References: 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil in Focus*. New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbo KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol*. 1990;66:131-151. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol*. 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Caravaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation*. 1987;75:1030-1036. 6. Midtbo K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology*. 1988;39:1025-1029.

Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomasia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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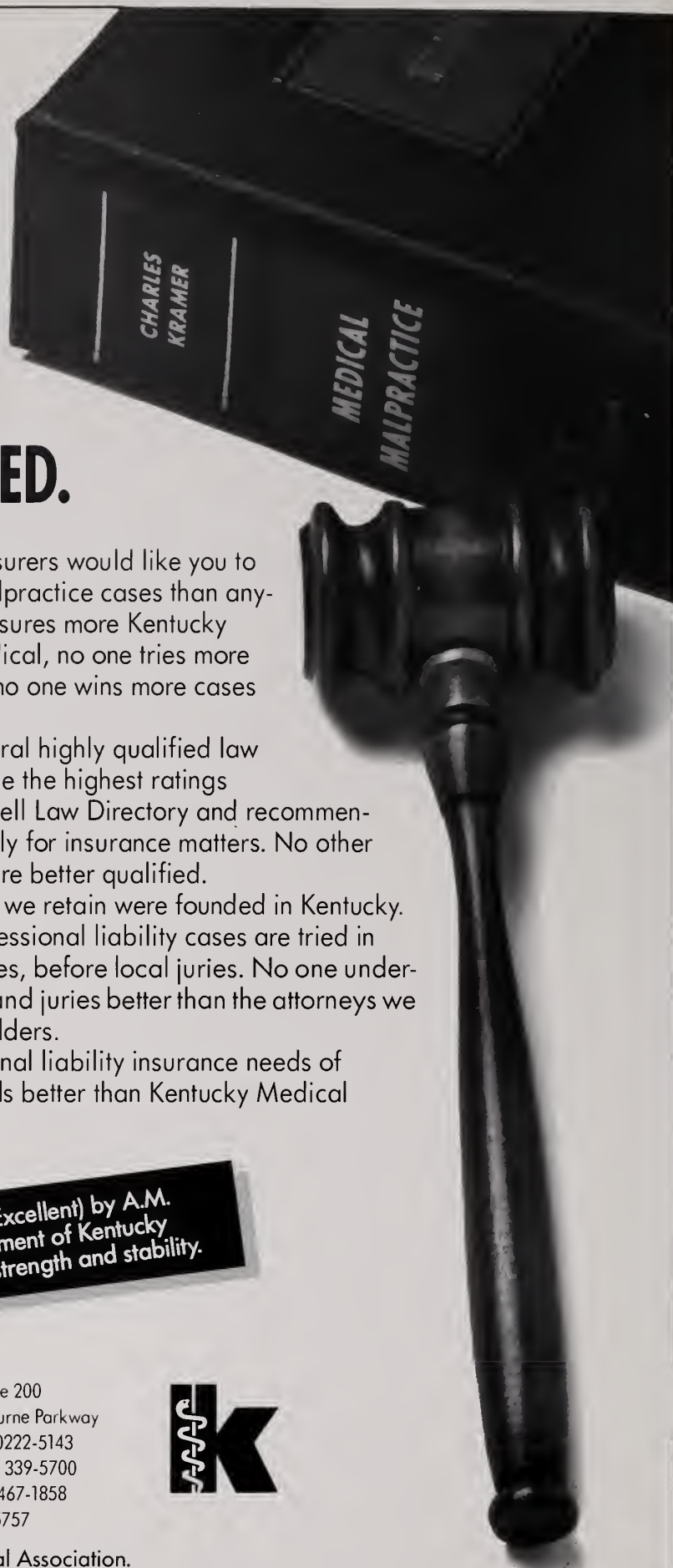
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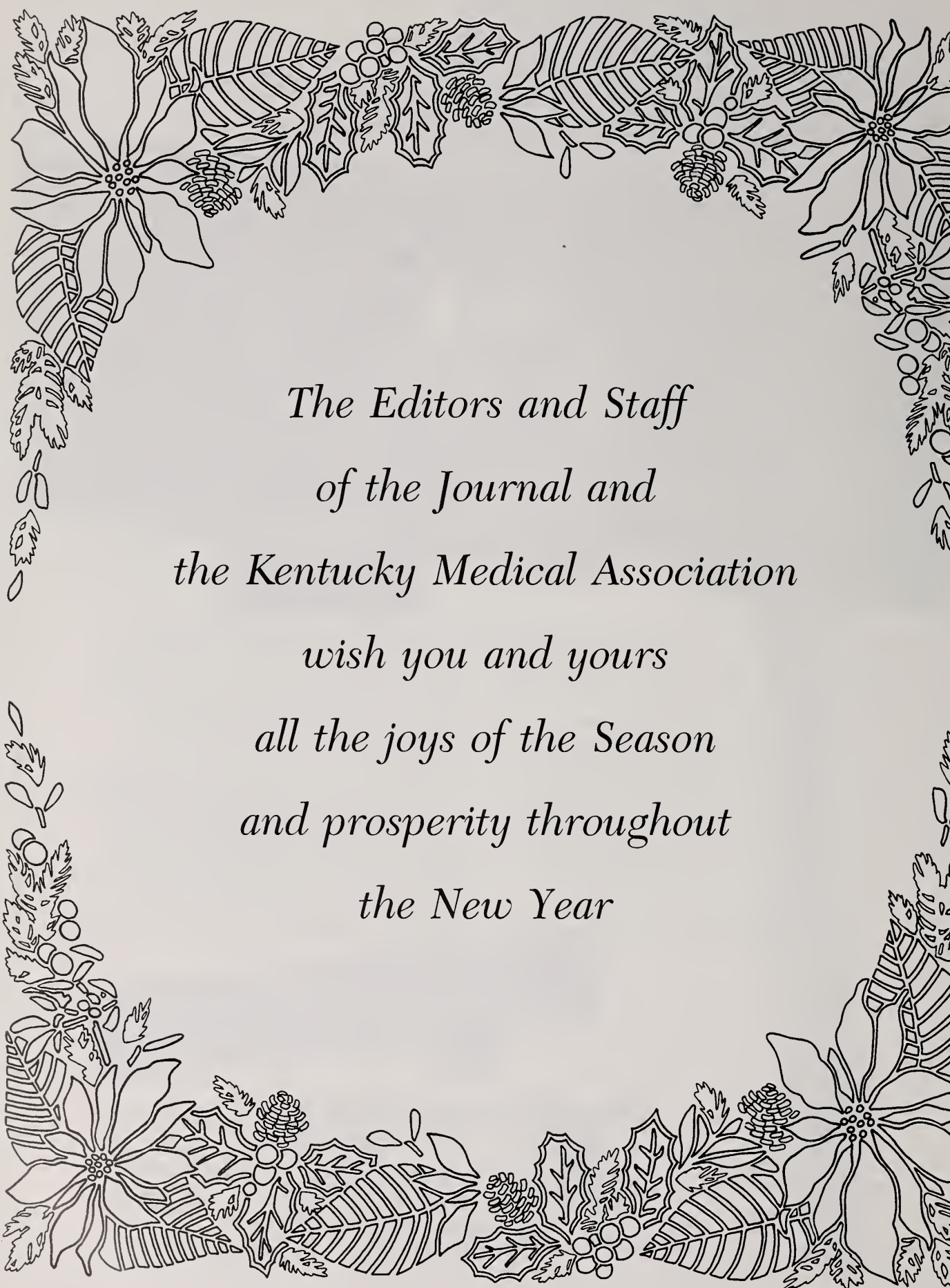
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DECEMBER 1992



COVER: Cover illustration by Lee Wode of Louisville. This issue of the Journal provides extensive coverage of the 1992 KMA Annual Meeting, which was held September 13-17 in Louisville. An overview begins on page 608, with House of Delegates coverage beginning on page 623.

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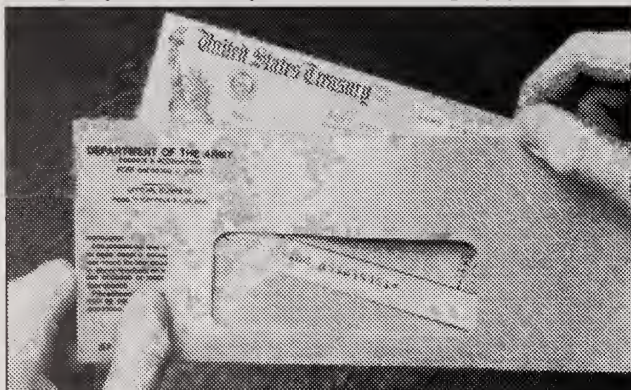
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Blastomycosis: A Reminder of Kentucky's Other Fungus

Ryland P. Byrd, Jr, MD; Cheryl L. Fields, MD; Jeff W. Dickerson, MD;
Judah L. Skolnick, MD; Thomas M. Roy, MD

Although not as common as Histoplasmosis, the disease caused by Blastomyces dermatitidis is also endemic in the Commonwealth of Kentucky. Greater clinical awareness of this systemic mycosis and the newer effective forms of treatment may lessen the significant morbidity and mortality of this potentially serious infection. To illustrate the varied manifestations of this illness, we contrast the presentation of an urban female with blastomycosis and atypical chest radiographic changes to the more classic features of blastomycosis described in the literature.

Introduction

The disease caused by the dimorphic fungus, *Blastomyces dermatitidis*, was first described by Gilchrist from his laboratory in Chicago in 1894.¹ While initially thought to be a disease confined to the geographic area of the Great Lakes, blastomycosis has now been reported from a variety of geographic locations in the world. In the United States, the majority of sporadic cases are reported from Kentucky, Tennessee, Arkansas, Mississippi, Virginia, and the Carolinas.²

The soil conditions that nurture *B. dermatitidis* are not fully understood. It is speculated that soil with a high organic material content, a low pH, and ecologically related to old animal habitats nurtures the growth of this fungus.³ Health care workers in southeastern states should be aware that the endemic areas for *Histoplasma capsulatum* and *B. dermatitidis* co-exist along the Mississippi, Missouri, and Ohio river basins.

Disturbance of the soil allows aerosolization of conidia that are then inhaled into the lungs. The conidia is converted to an 8 to 15 μ m yeast form that hematogenously spreads to distal organs such as skin, bone, and genitourinary tract. This dissemination may result in a multisystem

disease with multiple and varied manifestations. Generally patients become symptomatic 30 to 45 days after initial exposure.

The manner in which blastomycosis is expressed may depend on the host's cell-mediated immune status, but also on difference in virulence among collected strains of *B. dermatitidis*. The clinical spectrum of human blastomycosis has ranged from acute to chronic, mimicking the variation in clinical features seen with Kentucky's major systemic fungal disease, histoplasmosis. This presents a clinical dilemma that frequently allows blastomycosis to be overlooked since histoplasmosis is far more common.

We present a female patient with chronic blastomycosis who was symptomatic and had chest radiographic abnormalities. Her diagnosis was difficult to confirm. Definitive diagnosis and therapy for blastomycosis required open lung biopsy. Her atypical presentation will be contrasted to the more common presentations of this disorder. Current diagnostic and treatment modalities will be discussed.

Case Report

A 27-year-old white female was referred for evaluation of a chronic cough and progressive biapical cavitary disease. Her cough started 2 years earlier, and was productive of a greenish sputum that was occasionally blood streaked. She recalled no prodromal illnesses. She denied systemic symptoms of weight loss, fever, or chills. The patient did not smoke tobacco or marijuana. She had experienced no environmental or occupational exposure to toxins. She had no pets or livestock. She was an urban dweller without outdoor interests. She had not traveled recently. There was no family history of pulmonary diseases or unusual childhood illnesses.

Prior to referral the patient had undergone two fiberoptic bronchoscopic evaluations. The

From the Division of Respiratory and Environmental Medicine, University of Louisville School of Medicine, and the Louisville Veterans Administration Medical Center.

Blastomycosis



Fig 1

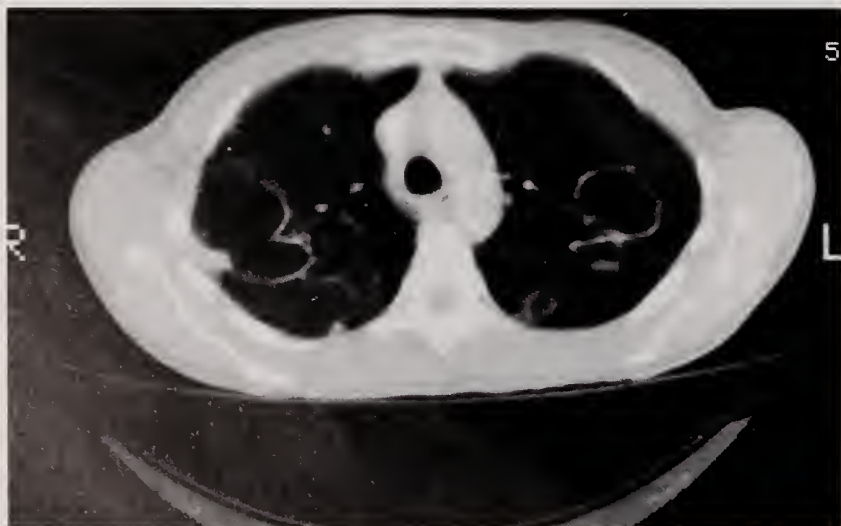


Fig 2

first bronchoscopist reported minimal inflammation of the right upper lobe mucosa. Bacterial, mycobacterial, and fungal cultures of respiratory secretions and sputum were negative. Transbronchial biopsies and bronchoalveolar lavage were not performed. Four months later a second bronchoscopy was performed. No mucosal abnormalities were seen. Cultures of the bronchial washings were negative. Changes consistent with mild chronic bronchitis were present on transbronchial biopsies.

She was a thin, young female in no acute distress. She was afebrile. Her vital signs were stable. Breath sounds in the upper lung fields were diminished. The remainder of her exam was normal. Clubbing was not present and there were no cutaneous lesions.

Multiple biapical thin-walled cavities were present on standard chest radiographs (Fig 1). Compared to previous roentgenograms, these lesions appeared to be enlarging. The patient's white blood cell count and differential were normal. Her biochemical profile was unremarkable. Her alpha-1 antitrypsin level was normal. Fungal serology by immunodiffusion and by complement fixation were normal. Her PPD was nonreactive. A serum protein immunoelectrophoresis was within normal limits. Multiple thin-walled cavities were seen in both apices on computerized chest tomography (Fig 2).

Due to the progressive nature of this patient's disease, an open thoracotomy and lung biopsy were performed. A granulomatous infiltrate with giant cells and broad based budding yeasts consistent with *B. dermatitidis* (Fig 3) were present on biopsy specimens. The cavities were partially cystic, lined with a squamous epithelium. Cultures of the biopsy specimen on Sabouraud's medium confirmed the diagnosis of *B. dermatitidis*.

Discussion

The vast majority of patients with blastomycosis are males between the ages of 20 to 70 years of age. It is an uncommon infection with a wide gamut of expression that ranges from asymptomatic primary pulmonary disease to the classic combination of cutaneous lesions, pulmonary symptoms, and history of fever and weight loss.⁴ The infection usually occurs sporadically and only a handful of epidemics have been reported.^{3,5,6}

Patients with acute illness are more likely to be febrile, and have chest pain and fever. Weight

loss is more common in the chronic form. Both groups have high incidence of cough and fatigue. Cutaneous lesions, arthritis, pleural friction rub, and hepatosplenomegaly are limited to the group with chronic disease. Chest radiographs are abnormal in 88% of patients. Thirty percent of patients in the chronic group will have pleural effusions.⁷ *Blastomyces* can be cultured from the pleural fluid.⁸

In chronic pulmonary blastomycosis, the upper lobes are the predominant site of disease. Chronic infections may present in any of a number of forms including consolidations, fibronodular infiltrates, mass-like lesions, interstitial infiltrates, miliary infiltrates, and cavitary lesions. In general the cavities are described as thick and smooth walled and containing no fluid.⁹ Our report represents only the second patient documented in the literature to have thin-walled cavities.¹⁰

In chronic extrapulmonary disease, almost any organ may be involved. The skin (40% to 80%), bone (20% to 40%), genitourinary (10% to 30%), and kidneys are most frequently involved. CNS involvement is rare, having been reported in less than 100 patients. Acute miliary blastomycosis is the most feared development because of the rapid progression to acute respiratory failure and 50% mortality.¹

By far the most common source of organisms will be the sputum. Although demonstration of the characteristic thick-walled, broad based, budding yeast on KOH wet-mounts provides the quickest and easiest method of screening suspicious lesions, an average of 7.9 ± 3.5 sputum samples may have to be examined before yeast forms are identified on smears.¹¹ This observation should encourage the clinician with a high index of suspicion for blastomycosis to persist in examining more than the usual 3 sputum smears. Experts caution that definitive diagnosis requires confirmation by culture.¹ In rare cases, the cells of *B. dermatitidis* may be confused with other fungi.¹²

Cultures typically require 3 to 5 weeks for growth. The mean time for a positive culture to be reported on a sputum sample is 18.7 ± 8.6 days and the first or second submitted sputum will be positive on culture.¹¹ Because the fungus is not a commensal or a noninvasive colonizer, recovery on culture of *B. dermatitidis* from any patient specimen confirms the diagnosis.

Skin testing with blastomycin is not a reliable diagnostic procedure. Fewer than half of proven



Fig 3

cases of blastomycosis have significant reactions to skin testing and there is extensive cross-reactions with other more common fungi, such as *Histoplasma capsulatum*.¹³

Diagnosis of blastomycosis by serologic techniques is also troublesome.¹⁴ The most widely used test for the serologic diagnosis of blastomycosis is complement fixation. This test has both low sensitivity (57%) and low specificity (30%). Fewer than 25% of patients with culture proven blastomycosis are detected by this method. Immunodiffusion as a serologic technique in blastomycosis is similarly limited by a lack of sensitivity. Only a small percent of culture proven cases of blastomycosis are positive. Cross reaction with histoplasmosis remains a problem. The newer antibody-detecting test, enzyme-linked-immunosorbent assay (ELISA), has a sensitivity of 80% and a specificity of 98% at serum titer of 1:16. Active infection is suggested by titers of 1:8-1:16. Titers greater than 1:16 suggest disseminated disease. Unfortunately, cross-reactions with antibodies to histoplasmosis and coccidioidomycosis limit this method as well. Complement fixation may be most useful as an indicator of response to treatment and following the course of disease in blastomycosis. Better serologic tests are being developed to directly detect *Blastomyces* antigen and

Blastomycosis

may become available in the near future.¹⁵

The decision to treat blastomycosis is controversial with most investigators suggesting treatment of all confirmed cases. Others decide on treatment depending on the stage and progression of disease. Acute pulmonary blastomycosis has, in general, a good prognosis even without treatment. Therefore a 2-week period of observation is recommended. If the patient improves, no treatment is necessary. If, on the other hand, the patient does not improve or clinically worsens, chemotherapy is indicated. Others argue that it is impossible for the clinician to distinguish between acute and chronic disease and that some acute disease that appears to resolve may aggressively reactivate.¹⁶ Because sporadic cases of endogenous reactivation have been observed even after adequate treatment, patients should be followed for several years.¹⁷

The mortality rate of untreated blastomycosis depends on the disease manifestations and host immunocompetence. However, a case-fatality ratio of 78% was quoted before antifungal therapy became available.¹⁸ With today's effective treatment, the case-fatality rate has been reduced to less than 10%.¹⁹

Amphotericin B is the treatment of choice in patients with a life-threatening infection, rapidly progressive disease, an immunocompromised state, and meningeal or brain involvement.^{16, 19} Rates of response to the gold standard have ranged from 66% to 93%. Enthusiasm for treatment with amphotericin B is tempered by the hazards, costs, and need for prolonged intravenous treatment.

The imidazoles inhibit the C-14 demethylation of lanosterol interrupting its conversion to ergosterol by binding to the fungal cytochrome P-450. This results in subsequent disruption of the cell membrane. This is effected without a significant effect on human cytochrome P-450 enzymes.¹⁹

In patients without life-threatening disease, meningeal involvement, or central nervous system disease who are immunocompetent, ketoconazole is an effective treatment.²⁰ Ketoconazole requires an acidic environment for optimal drug absorption, and caution must be taken to avoid antacids and H₂ blockers. Patients with achlorhydria will require alternate therapy. Gastrointestinal complaints, rash, and pruritus have occurred with ketoconazole. More serious adverse effects such as hepatotoxicity or depression of adrenal and testicular function are occasionally seen, but

are usually manageable. Doses of 400 mg/day administered for 6 months are usually adequate treatment for blastomycosis. If there is no improvement after 1 month, then a higher dose of 600 or 800 mg/day may be indicated with proper attention to potential side effects. An underlying immunocompromised state or pre-existing hepatic disease may represent relative or absolute contraindications to the use of ketoconazole.

Fluconazole is a relatively new antifungal agent which appears to show significant efficacy against blastomycosis.²¹ It has the advantage of both intravenous and oral administration, high bioavailability, a long half-life, and penetration into the central nervous system. Because this agent is eliminated by the kidneys, dose adjustments are required in patients with renal insufficiency. Adverse effects are uncommon. The clinician must be aware that the agent cross-reacts with a number of other commonly prescribed medications such as tolbutamide, warfarin, rifampin, phenytoin, and cyclosporine. Despite these precautions, its effects on steroidogenesis are much less than ketoconazole. Single daily doses of 100-400 mg are recommended in the absence of renal impairment.

Itraconazole is an oral triazole with a broad spectrum of antifungal activity.²² It has been used successfully against blastomycosis, but only on a very limited basis. The medication is very well tolerated. More tests will be needed to establish its place in the therapeutic armamentarium.

Hydroxystilbamidine, the only effective treatment for blastomycosis before amphotericin B was marketed in 1956, is largely of historical interest now. Its use has been replaced by the newer imidazole agents. It should be remembered that it is still an effective intravenous alternative when other drugs are not tolerated or are contraindicated. There is a 30% relapse rate in observed cavitary blastomycosis. The drug is relatively non-toxic, with occasional hepatitis the primary concern.

In summary, although disease from *B. dermatitidis* is rare in the United States, it is not uncommon in the Commonwealth of Kentucky. The exact incidence and epidemiology of the disease is largely unknown because there is no reliable immunologic marker of previous infection. A knowledge of the clinical and pathologic features of blastomycosis is important. A high index of suspicion is essential to avoid a misdiagnosis that might lead to inappropriate medical or surgical therapy.

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A. Evan Overstreet, MD
Editor

Substance Abuse: AMA Fights Legal and Illegal Killers

Between 40 and 50 million Americans smoke. And over 400,000 die each year from tobacco-related disease alone. Even people who don't smoke are affected. Passive smoking kills as many as 53,000 nonsmoking Americans every year. This abuse drains over \$90 billion a year in medical expenses and lost productivity and wages.

Now add in the toll of alcohol and drug abuse.

Alcohol abuse cost our economy \$33 billion in lost earnings each year; drug abuse tops \$7 billion.

The toxicity of alcohol and drug abuse spreads into all areas of American life including family violence and crime. According to studies, 54% of prisoners admit to being under the influence of drugs at the time of their offense. In 1989, 45% to 83% of those arrested tested positive for one or more drugs.

What is the AMA doing?

The American Medical Association and its membership support a tobacco-free society by the year 2000.

The AMA has helped ban smoking on airplanes, began a mandate for smoke-free hospitals, and supported the Environmental Protection Agency in its classification of passive-smoke as a known-cause of cancer.

Reducing smoking among our nation's children, young women, minorities and those Americans with less formal education was the dominant issue of the "Final Report: Tobacco Use in America." Another key concern is the need for public policy-makers to recognize the powerfully addictive nature of nicotine which the report covers in its section on legislative and activist strategies.

The AMA supports efforts to ban and/or restrict tobacco advertising and promotion. We work to restrict teenagers' access to tobacco products by banning vending machine sales, raising the legal age of purchase to 21 and halting cigarette give-away promotions.

The AMA's policy-setting House of Delegates has gone to bat against smoking by opposing the tobacco industry's lucrative sponsorship of sports by calling for:

- major league baseball owners to ban smoking in parks,
- stopping tobacco company sports sponsorship and advertising, and
- cigarette warnings that say: "Smoking is ADDICTIVE and may result in DEATH."

In the continuing war on drugs and alcohol, the AMA supports its physicians' local efforts by publishing material to help physicians identify and evaluate drug abuse in their young patients and by developing a training program for physicians dealing with patients at high risk of drug abuse.

The AMA also works with federal and state enforcement agencies to create model systems to prevent prescription drugs from being diverted to "street" markets and drug abusers.

Working with the American Bar Association, the AMA is helping to educate junior high school students on the grim consequences of drug and alcohol abuse.

And, the AMA has demanded that alcohol advertising bear warning labels.

What can you do?

To battle tobacco use, support efforts to protect nonsmokers from passive smoke; urge your local pharmacist to refrain from selling tobacco products; encourage school systems to become smoke-free; ask for nonsmoking restaurant seats, hotel rooms and rental cars; and write the publishers of magazines and newspapers to remove tobacco advertisements.

To combat drug and alcohol use, teach healthy lifestyles by example.

For all of us, the value of real-life experiences and achievement are the durable mainstays of pleasure and fulfillment.

Happy Holidays

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142ND KMA ANNUAL



Top: Newly installed President William B. Monnig, MD, (second from left) is pictured with, LtoR, Vice President David C. Liebschutz, MD, President-Elect Ardis Dee Hoven, MD, and Secretary-Treasurer William P. Vonderhaar, MD. Left: Immediate Past President S. Randolph Scheen, MD, shared a light moment with President Monnig. Right: Awards Chairman Nelson B. Rue, MD (L) presented the Distinguished Service Award to James B. Holloway, Jr, MD.



MEETING



Nelda Barton-Collings of Corbin was honored with the KMA Award. Dr Rue made the presentation.



Top: KMA history was made as Ardis Dee Hoven, MD, of Lexington, became the first woman ever to be escorted to the KMA House of Delegates podium to serve as President-Elect. Dr Hoven received two standing ovations from her peers. Her escorts were Past Presidents Richard F. Hensch, MD (L), and Preston P. Nunnelley, MD. Center: President Monnig is pictured with his lovely wife, Donna. Bottom: Board Chairman Russell L. Travis, MD, administered the presidential oath to Dr Monnig.



Top: AKMA Past President Pam Blackstone (L) presented AMA-ERF checks to UofL's Alfred L. Thompson, Jr, MD, and UK's Carol Elam (standing in background). Center: President Monnig speaks with KMA Executive Vice President Bob Cox, who recently celebrated his 30th anniversary with the Association. Bottom: Past President S. Randolph Scheen, MD, presided over a special forum on health care reform.



Inauguration

William B. Monnig, MD, an Edgewood urologist, was inaugurated 1992-93 President of KMA at the 142nd Annual Meeting held in Louisville, September 13-17. Dr Monnig, a graduate of the University of Cincinnati College of Medicine, has served KMA as 8th District Trustee, Chairman of the Board of Trustees, Vice President, President-Elect, and on numerous committees including State Legislative, Medico-Legal, Hospital Medical Staff Section, Committee on Medical Insurance, and as Chair of the Building Committee.

Elections

Ardis Dee Hoven, MD, a Lexington infectious disease specialist, was elected to the office of President-Elect. A graduate of the University of Kentucky College of Medicine, Dr Hoven is the first woman to ever be elected to the KMA Board. She just completed a term as Vice President and has chaired the Ad Hoc Committee on the Development of AIDS Guidelines, Committee on Medicare and Other Governmental Medical Programs, and from 1987 to present has chaired the Committee on Community and Rural Health. She also currently serves on the Professional Liability Insurance Committee and as an AMA Alternate Delegate.

David C. Liebschutz, MD, a Danville surgeon, was elected to the office of Vice President. Dr Liebschutz' service to KMA includes Alternate Trustee, 1980-86, and 12th District Trustee from 1986 to 1992.

Five new Trustees were elected: Harry W. Carloss, MD, Paducah, 1st District; William H. Klompus, MD, Madisonville, 3rd District; Salem M. George, MD, Lebanon, 4th District; Scott B. Scutchfield, MD, Danville, 12th District; and E. D. Roberts, MD, Pikeville, 14th District.

In other House elections, Wally

O. Montgomery, MD, Paducah, and Robert R. Goodin, MD, Louisville, were reelected AMA Delegates. Ardis Dee Hoven, MD, Lexington, and Bob M. DeWeese, MD, Louisville, were reelected AMA Alternate Delegates.

The Board of Trustees elected the Executive Committee members to serve with the President, President-Elect, Vice President, and Secretary-Treasurer for the 1992-93 KMA year. Russell L. Travis, MD, Lexington, was reelected Chairman of the Board, and John W. McClellan, MD, Henderson, was elected Vice Chairman. William H. Mitchell, MD, Richmond, and Don R. Stephens, MD, Cynthiana, were named as Trustees-at-Large.

Five physicians were elected by the House of Delegates to serve on the 1992 Nominating Committee.

Members elected were:

Joseph G. Weigel, MD
Somerset, Chairman
John V. Borders, MD
Lexington
William C. Harrison, MD
Owensboro
John M. Karibo, MD
Louisville
Frank K. Sewell, Jr, MD
Henderson

President's Luncheon

The President's Luncheon guests honored outgoing President S. Randolph Scheen, MD, and witnessed the installation of William B. Monnig, MD, as the 142nd President of KMA.

In his Inaugural Address, Dr Monnig focused on KMA's commitment to meaningful health care reform. Notable comments included, "The Kentucky Medical Association is well organized and well staffed to be a leading partner in health care. We represent the essential element, the lynchpin, the keystone to quality patient care — the practicing physicians of this state. . . . The KMA is committed to meaningful health care reform. We can be a strong partner to those who want to



Top: Speaker Danny M. Clark, MD, called the House to order. Center: Andrew M. Moore, II, MD, President of the Fayette County Medical Society, presented President-Elect Ardis Dee Hoven, MD, beautiful long-stemmed red roses and best wishes from their Society. Bottom: Governor Brereton C. Jones addressed the Wednesday evening House of Delegates meeting.





Top: 11th District Trustee William H. Mitchell, MD (L), Richmond, enjoyed an opportunity to chat with Tom R. DeMeester, MD, a noted guest speaker from Los Angeles. Center: Clifford C. Kuhn, MD, Louisville, spoke to the KMA-MSS and RPS group. Bottom: Somerset Delegates, LtoR, Donald E. Brown, MD, Joseph G. Weigel, MD, and James D. Crase, MD, discussed the issues with Russell Springs Delegate Haney M. Oghia, MD. Standing in the background is William L. Miller, MD, Morgantown, a former KMA Trustee.

create a cooperative process for health care reform. . . . We pledge ourselves to actively participate in any good faith effort to revise the health care system so that all patients in the state of Kentucky receive adequate health care at reasonable costs. . . . We refuse to passively accept the dictates of a reform movement that will not acknowledge our essential role to the process." Dr Monnig's

address is printed in its entirety in the October 1992 *Journal*.

DSA Award

The Association's most prestigious honor, the Distinguished Service Award, was bestowed upon James B. Holloway, Jr, MD, a retired Lexington surgeon. He was honored at the President's Luncheon for not only his contributions to the profession but also to his community.

Dr Holloway is a US Navy veteran, Past President of the Fayette County Medical Society, and has been very involved with the University of Kentucky School of Medicine. He has served KMA as Vice President, two terms as Trustee of the 10th District, as President in 1983-84, and on numerous committees. His two terms as Chairman of the KMA Board of Trustees came during the volatile mid-1970s when the professional liability insurance crisis was at its peak. Under Dr Holloway's Chairmanship, the KMA Board of Trustees made the decision to form Kentucky Medical Insurance Company. He was extensively involved in formation of the company, served as Vice Chairman of the KMIC Board for several terms, and was a guiding influence in the success of the company.

Dr Holloway's activities on the local and community level are legendary. He played a leadership role in establishing the Bluegrass Regional Health Planning Council and developed a board structure that provided professional medical input into the first HMO in Lexington. He was actively involved in the Fayette county Medical Society's option to purchase a building to house the county society and the Central Kentucky Blood Center, which was particularly crucial to the blood center as it sought to meet the needs of patients in 54 counties.

He received worldwide recognition for his civic contributions



The 30th KEMPAC Seminar Banquet featured the three speakers shown at the right. From the top: senatorial candidate David Williams; State Senator Joe Wright speaking for Senator Wendell Ford who was unable to attend; and AMPAC Chairman Faser Triplett. Bottom photo: Samuel Jerry King, MD, Pikeville, KEMPAC Chairman, addressed the House.



by chairing the World Championship Three Day Equestrian Event at the Kentucky State Horse Park in 1978. This required more than a 2 year intensive effort and served as the opening of the Kentucky State Horse Park. For those efforts he received Fayette County's most prestigious award, the Community Service Award. He was Kentucky State Chairman for the US Equestrian Team from 1976-1981.

In his presentation of the award to Dr Holloway, Nelson B. Rue, MD, Chairman of the Awards Committee, included these comments, "Several years ago our nominee retired from active medical practice. He was a skilled clinician and a physician whose integrity was unquestioned. He is presently Medical Director of Kentucky's Medicare program and has been a remarkable advocate for Medicare patients and the physicians who treat those patients. He is well respected both by his peers and those for whom he now toils. Within the profession he is known as an advocate of continuing education, quality medical care, and membership and participation in the medical community. There is no one more supportive of the federation of medicine than our 1992 recipient."

Lay Person Award

The KMA Award, which is awarded to a lay person who has made significant contributions to the medical community, went to Nelda Barton-Collings of Corbin.

Following achievement of her undergraduate education at Western Kentucky University and Cumberland College, Ms Barton-Collings began her extensive involvement in the health care arena. She is President and Chairman of the Board of various long-term care homes throughout Kentucky and is former President of the Kentucky Health Care Facilities Association. Her particular interest in

the problems of elderly Americans led to an appointment to the federal Council on Aging which requires a Presidential nomination and a US Senate confirmation. She has also served as a delegate to the White House Conference on Aging and is a board member of the University of Kentucky Foundation Center on Aging.

Extensive involvement in Kentucky and national politics includes service as Republican National Committee Woman for Kentucky since 1968, a delegate to the Republican National Convention on numerous occasions, the first Kentucky woman to address a Republican national convention when in 1980 she spoke on "The Business of Caring for the Elderly," and as the 1980 and 1984 Kentucky co-chairman of the Reagan-Bush campaign.

After reciting the recipient's exhaustive list of state and national accomplishments, Awards Chairman Rue concluded with these comments, "However, our nominee has never shirked her duties and the needs of her local community and family. She has been a Cub Scout Den Mother, President of her local PTA, member of the Fair Housing Task Force, and held various offices in the federation of Womens Clubs. She is recognized throughout the state as one of the outstanding business and community leaders in Kentucky. Our distinguished recipient was a Charter Board Director of Leadership Kentucky and was elected as the first woman to serve as chairman of the Kentucky Chamber of Commerce Board of Directors. She has been honored with numerous local, state, and national awards and her career is an example of the impact an individual who really cares and believes in the free enterprise system can have on society. Adversity in her life has always been a challenge rather than an obstacle. She has

continually striven to see that her city, her state, and her nation became a better place. She has involved herself in numerous economic activities, particularly on behalf of her rural heritage and has given freely of herself in addressing the needs of the less fortunate members of our society."

Forum on Health Care Reform

During the Monday House of Delegates, President S. Randolph Scheen, MD, moderated a special forum on health care reform. The forum was open to all members. Participating on the panel were Leonard Heller, PhD, Secretary of the Kentucky Cabinet for Human Resources, and Chairman of the Governor's Commission on Health Care Reform; Senator Michael Moloney, a member of the Governor's Commission and Chairman of the Senate Appropriations and Revenue Committee; and Dr Russell L. Travis, who represented KMA.

Auxiliary AMA-ERF

During the first meeting of the House of Delegates, Pam Blackstone, AKMA Past President, presented AMA-ERF checks to the two medical schools on behalf of the Auxiliary. Since 1950, the AMA-ERF has continually been supportive of quality medical education, with contributions now exceeding \$2 million annually. The extraordinary fund raising efforts of the AMA Auxiliary and the generosity of contributing medical families and private enterprise continue to secure AMA-ERF as a viable support for medical education.

In Kentucky, AMA-ERF funds are given proportionally to the two medical schools as designated by the donors. Alfred L. Thompson, Jr, MD, Associate Vice President for Hospital Affairs, University of Louisville, accepted a check from Mrs Blackstone for \$33,718.95, and Ms



Top: John W. Hollowell, MD (L), President of the Medical Society of Virginia, enjoyed a break in the action with Delegates Arthur H. Keeney, MD, and Virginia T. Keeney, MD, of Louisville. Bottom LtoR: Intently studying the reports are Delegates Charles L. Shields, MD, Paducah; Wallace L. Past, Jr, MD, Campton; John H. Doyle, MD, Louisville; Ray A. Cave, MD, Leitchfield; Harry W. Carlross, MD, and Larry C. Franks, MD, both of Paducah.

Carol Elam, Assistant Dean for Admissions, University of Kentucky College of Medicine, accepted a check for \$14,148.81.

Fifty-Year Members

Those KMA member physicians who have been practicing medicine for 50

years or more were recognized during the President's Luncheon. Achieving that status this year are: Drs Harold F. Berg, Jack C. Blackstone, Eli C. Boggs, James G. Boggs, Walter L. Boswell, J. Ray Bryant, William H. Bryant, William H. Christopherson, Caleb H. Chu, Albert G. Cullum, Lawrence A.



Top: Included in the Lexington contingent were, LtoR, Delegate Andrew R. Pulito, MD; 10th District Alternate Trustee Gary R. Wallace, MD; and Delegates John M. Fox, MD, and Barry N. Purdom, MD. Bottom: Louisville Delegates included, LtoR, Susan M. Berberich, MD; Peter C. Campbell, MD; Linda H. Gleis, MD, and John M. Farmer, MD. Photos at right from the top: Joining the debate from the floor were 12th District Trustee Scott B. Scutchfield, MD; Delegate Eugene H. Shively, MD, Campbellsville; and House Speaker Danny M. Clark, MD, Somerset.

Davis, Ralph M. Denham, Elbert L. Dennis, Lewis Dickinson, Frank W. Gwinn, Clarence I. Haeberle, Cathryn C. Handelman, Robert J. Hoffmann, James M. Keeton, Ji-toong Ling, Jules J. McNerney, Condict Moore, R. Parnell Rollings, Charles C. Rutledge, John J. Sonne, Joseph E. Stephenson,

Robert C. Tate, and Claude C. Waldrop.

In Memoriam

During the first House of Delegates meeting, Dr William P. VonderHaar requested that the audience stand for



Top: Donald J. Swikert, MD (R), Florence, Alternate Delegate to AMA, presents his views to Delegate Rudy J. Ellis, Jr, MD, of Louisville. Center: Relaxing during a break in House action are, LtoR, 5th District Trustee Joseph E. Kutz, MD, Louisville; Harry T. Faulconer, MD, Lexington; and Darius Ghazi, MD, a Louisville Delegate. Bottom: Auxilian Diana Moore is pictured with her husband J. Michael Moore, MD (R), a Lexington Delegate; Carl Cooper, Jr, MD, Bedford, KMA Past President; and Dr Cooper's son J. Gregory Cooper, MD, Cynthiana, KMA Alternate Delegate to AMA.

a moment of silence in memory of those physician members who had died in the last year. A list of the deceased appears on page 597 of this *Journal*.

KMA-MSS and RPS

The second annual meeting of the KMA Medical Student Section and Resident Physicians Section, held September 15, attracted approximately 65 attendees. In keeping with the

overall Annual Meeting theme of "Medical Challenges in an Age of Risk," medical students and residents heard a presentation on "How to Avoid Getting Sued," by Randolph Starks of Kentucky Medical Insurance Company. In addition, Clifford Kuhn, MD, Louisville psychiatrist and comedian, spoke on "Humor in Medicine."

Judy Linger, MD, UK resident who also serves on the AMA-RPS Governing Council, reported on several major national legislative issues of concern to students and residents and William Monnig, MD, KMA President, challenged the group to get involved in issues which will affect their future practice of medicine.

KEMPAC

The 30th KEMPAC Seminar Banquet was held during this year's Annual Meeting on Monday, September 14, at the Hyatt Regency Hotel, Louisville. A large audience of physicians, spouses, Kentucky State Representatives, Senators, and their staff were addressed by senatorial candidates David Williams and State Senator Joe Wright speaking for Senator Wendell Ford who was not able to be present. AMPAC Chairman Faser Triplett, MD, Jackson, Mississippi, brought greetings from the national office. Samuel Jerry King, MD, Pikeville, KEMPAC Chairman, presided at the meeting.

House Action Summary

The 1992 KMA House of Delegates adjourned on September 16, 1992, after making some important decisions on a number of health care issues. The evening began with Kentucky's Governor Brereton Jones making a personal appearance to address the Delegates concerning his health care reform program. Highlights of actions taken by the



Top: Listening intently to a colleague's views are Delegates G. Irene Minor, MD, Berea, and Richard A. Stone, MD, Richmond. **Center:** 3rd District Alternate Trustee Charles R. Dodds, Earlington, (far left) shares in a conversation with his wife, AKMA President Beryl Dodds, and Thomas E. Bunnell, MD, an Erlanger Delegate. Standing at right is Delegate Wallace R. Alexander, Madisonville. **Bottom:** LandR, Louisville Delegates James E. Redmon, MD, and David H. Bizot, MD, talked informally with 5th District Alternate Trustee Larry J. Wilson, also of Louisville.



House are listed below. Please refer to the House of Delegates section in this *Journal* for a complete text of the Committee Reports and Resolutions.

- Called on the Kentucky Board of Medical Licensure to require participation by physicians in continuing medical education as a condition of licensure. The participation in required CME consists of the acquisition of 60 hours within a three-year period.
- Recommended KMA support the joint collaborative practice of physicians and ARNPs; endorse legislation to permit ARNPs to prescribe under written protocol and formulary approved by the supervising physician and appropriate licensing authorities; require that ARNPs complete established pharmacological prerequisites and maintain continuing education in the use of prescribed substances in chosen specialties; support the concept that there should be well-defined limits on the number of ARNPs any physician may supervise within closely defined geographic areas; and establish safeguards through legislation to prohibit independent and unsupervised practice.
- The House of Delegates revised KMA's position on Certificate of Need. Private offices and clinics of physicians and other practitioners of the healing arts should be exempt from CON requirements, including but not limited to licensure, supervision, regulation, or control regulated by the Commission on Health Economics Control, *except as they propose to provide equipment which costs exceed \$250,000, with adjustments for inflation.*
- Reaffirmed its policy regarding coordination of state legislative activities. All state legislative proposals are to be coordinated by and channeled through the

Committee on State Legislative Activities. Retain composition, function, and authority of Quick Action Committee. The composition, priority, manner, and time of introduction of state legislative proposals are to be left to the discretion of the Chairman of the Committee on State Legislative activities and the Quick Action Committee.

- Designated the officers and Board of



Trustees to serve the organization in all negotiations associated with development and implementation of health care reform considered by the 1992 special session of the Kentucky State Legislature called by Governor Brereton Jones.

- Adopted the current edition of Davis' *Rules of Order* as the parliamentary guide for all deliberations.
- Directed KMA to consult heavy volume providers of mammography screenings to seek out level of costs and expenses and requested KMA to get a list of current contracts from the Department for Health Services of counties that are currently providing mammograms. In addition, KMA should publicize that there is a mammography screening program for indigent women available, as well as a subsidy for this program through SB 41 of the 1990 General Assembly.
- Encouraged the Kentucky General Assembly to increase its attention to the serious health problems related to tobacco products, as well as encouraging physicians to intensify educational efforts directed to patients on the deleterious effects of tobacco use.
- Urged the KMA to work with specialty societies, state medical schools, and individual members to coordinate preceptorships for medical students in private practice primary care settings and have training episodes begin prior to the third year of medical school study.
- Directed KMA to encourage the Kentucky Cabinet for Human Resources to survey out-of-state physicians trained in Kentucky to determine factors contributing to their decisions to leave the state and share with appropriate organizations, if such information is not currently available.
- Directed KMA to work with medical schools to have 50% of their graduates enter primary care programs, and insure that 40% of graduates enter the practice of primary care medicine, and enlist

aid of other appropriate agencies and organizations in this effort. Also requested KMA to actively encourage and support the strengthening of existing family practice residency programs in the state with regard to funding, faculty, and clinical experience.

- Encouraged the Impaired Physicians Committee to explore the possibility of including in its program physically handicapped physicians and their need for alternative career choices.
- Opposed any legislative proposals that institute an involuntary service requirement for physicians trained in Kentucky.
- Urged the KMA to work with the Kentucky General Assembly to increase the excise tax on the sale of cigarettes.
- Direct KMA to work with the Kentucky Board of Education to include in the curriculum appropriate information for teachers to educate their students about the hazards of ultraviolet radiation and tanning parlors.
- Expressed sincere thanks and appreciation to S. Randolph Scheen, MD, for his exemplary service and devotion to the KMA for more than 25 years.
- Directed KMA to further educate physicians on recognizing symptoms of domestic/interpersonal violence. Urge all county medical societies to work with local committees to educate communities on the serious issue of domestic/interpersonal violence.
- Encouraged medical schools to create mentor groups with professors, residents, and medical students to discuss the benefits of membership to the KMA.
- Recommended that all high-risk newborns covered by Medicaid be followed by their physicians and their designates to insure PKU testing, infant immunizations, access to the WIC program, preventive care, and repeat pregnancy education. The importance of preventive health measures including immunizations,

is recognized for all infants and children in the Commonwealth.

- Recommended KMA pursue a separate committee to study infant mortality and fetal death.
- Encourage the Legislature to enact restrictions on smoking in the next and subsequent sessions of the Kentucky General Assembly, including an indoor air standard, a ban on smoking from all school buildings and school-sponsored events, a ban on sale of tobacco products in vending machines except in areas off limits to minors, use tobacco knowledge for criteria under framework of education reform, ban tobacco company sponsorship of youth athletic events, require a retailer selling tobacco products to have a license, ban distributions of free tobacco product samples, restrict tobacco advertising to black-and-white printed text without pictures, and repeal "smokers rights" provisions.
- Seek administrative and legislative commitment to amend the Kentucky Education Reform Act (KERA) to require schools (grades K-12) to include health education in the curriculum.

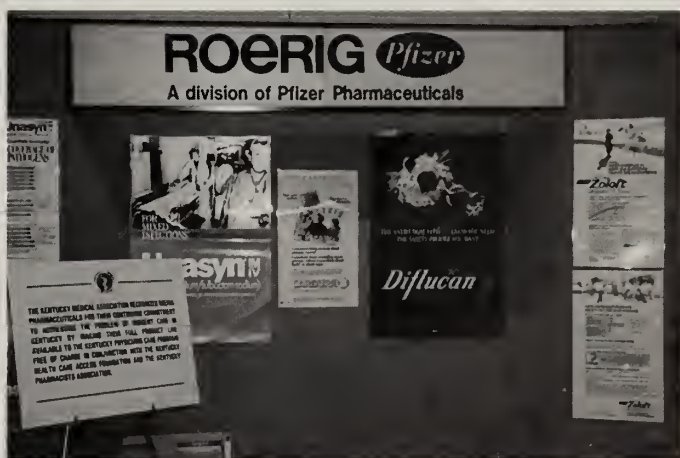
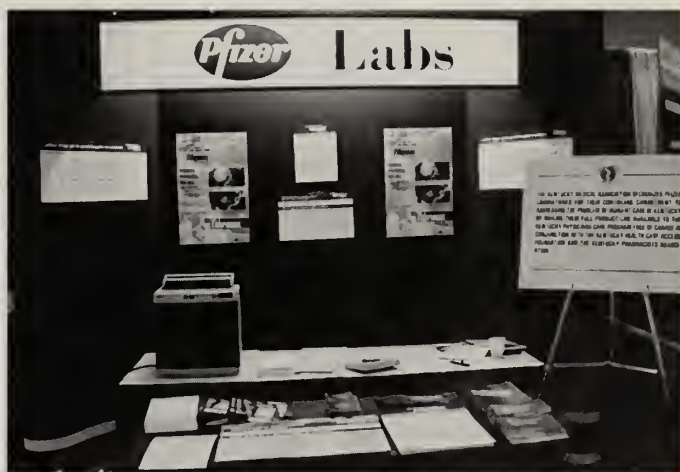
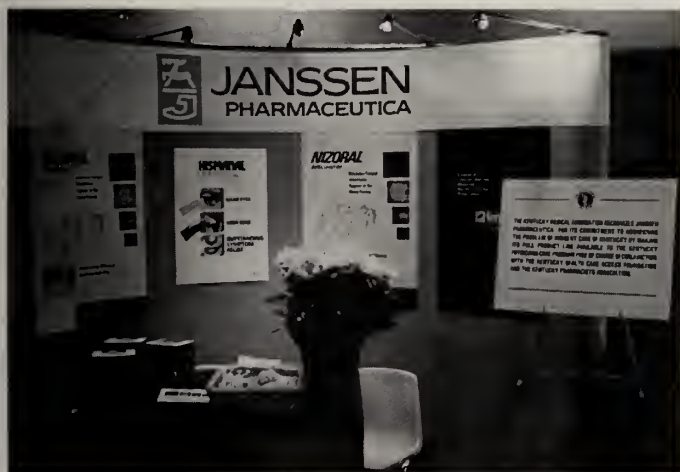
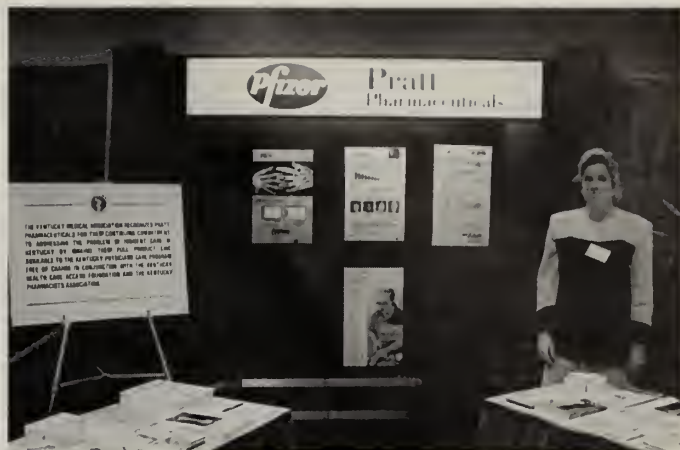
Attendance

This year's KMA meeting attracted almost 2,500 attendees. Physicians numbered 1,073 and medical students 330, resulting in a very successful 142nd KMA Annual Meeting at the Hyatt Regency Hotel/Commonwealth Convention Center in downtown Louisville. The 1993 Annual Meeting will also be held in Louisville. The Board of Trustees has again selected the very accommodating and spacious Hyatt Regency Hotel/Commonwealth Convention Center to house the meeting. Over 22 specialty groups and an estimated 2600 registrants are expected to attend.

Please mark your calendars to attend the 1993 KMA Annual Meeting to be held September 26-30. *KMA*

THANK YOU!

KMA appreciates the support and participation of all of our Annual Meeting exhibitors. At this time, we wish to extend a special thanks to the pharmaceutical companies pictured here who are currently providing their prescription drugs free of charge to eligible patients through the Kentucky Physicians Care Program.



Was Your Delegate Present?

ROLL CALL

1992 House of Delegates

KMA Annual Meeting

OFFICERS

		First Meeting	Second Meeting
Speaker	Danny M. Clark	Present	Present
Vice Speaker	C. Kenneth Peters	Present	Present
President	S. Randolph Scheen	Present	Present
President-Elect	William B. Mannig	Present	Present
Vice-President	Ardis D. Haven	Present	Present
Secretary-Treasurer	William P. VanderHaar	Present	Present
Delegate to the AMA	Danald C. Barton	Present	Present
Delegate to the AMA	Harald L. Bushey	Present	Present
Delegate to the AMA	Robert R. Gaadin	Present	Present
Delegate to the AMA	Wally O. Mantgamery	Present	Present
Alternate Delegate to the AMA	J. Gregory Cooper	Present	Present
Alternate Delegate to the AMA	Bob M. DeWeese	.....	Present
Alternate Delegate to the AMA	Ardis D. Haven	Present	Present
Alternate Delegate to the AMA	Danald J. Swikert	Present	Present

TRUSTEES

District		First Meeting	Second Meeting
First	Robert P. Meriwether	Present	Present
Second	Jahn W. McClellan, Jr	Present	Present
Third	William L. Miller	Present	Present
Fourth	Lucian Y. Mareman, II	Present	Present
Fifth	Joseph E. Kutz	Present	Present
Sixth	Jerry W. Martin	Present	Present
Seventh	Ronald L. Walldridge	Present	Present
Eighth	Mark F. Pelstring	Present	Present
Ninth	Danald R. Stephens	Present	Present
Tenth	Russell L. Travis	Present	Present
Eleventh	William H. Mitchell	Present	Present
Twelfth	David C. Liebschutz	Present	Present
Thirteenth	Charles T. Watson	Present	Present
Fourteenth	James R. Pigg	.....	.....
Fifteenth	Paul R. Smith	Present	Present

ALTERNATE TRUSTEES

District		First Meeting	Second Meeting
First	Dan M. Miller	Present	Present
Second	Christopher R. McCay	.....	.....
Third	Charles R. Dadds	Present	Present
Fourth	Salem M. Gearge	.....	.....
Fifth	Larry J. Wilson	Present	Present
Sixth	Jahn D. Gaver	Present	.....
Seventh	Jahn Michael Watts	.....	.....
Eighth	Jahn D. Amman	.....	.....
Ninth	Robert L. McKinney	Present	Present
Tenth	Gary R. Wallace	.....	Present
Eleventh	G. Irene Minar	Present	Present
Twelfth	Scott B. Scutchfield	Present	Present
Thirteenth	Bruce M. Stapleton	.....	Present
Fourteenth	Nicholas R. Jurich	.....	.....
Fifteenth	Ragelia A. Acosta	Present	Present

PAST PRESIDENTS

		First Meeting	Second Meeting
Past President	Prestan P. Nunnolley	Present	Present
Past President	Nelson B. Rue	Present	Present
Past President	Bob M. DeWeese	.....	Present
Past President	Danald C. Barton	Present	Present
Past President	Richard F. Hench	Present	Present

DELEGATES FIRST DISTRICT

		First Meeting	Second Meeting
BALLARD CALLOWAY	R. Gary Marquardt Dan Miller	Present	.....
CARLISLE FULTON GRAVES	Charles E. Bea Robert D. Fields Bruce C. Smith Stephen Burkhardt	Present	.....
HICKMAN LIVINGSTON MARSHALL MCCRACKEN	Harry W. Carllass Larry C. Franks Jahn D. Noonan Charles B. Russ Charles L. Shields	Present	Present

SECOND DISTRICT

		First Meeting	Second Meeting
DAVIESS	William C. Harrison Jahn T. Houston Philip B. Hurley Ronald M. Jahnsan Albert H. Jaslin R. J. Phillips, Jr	Present	Present
HANCOCK HENDERSON	Thomas M. Gadiant Frank K. Sewell, Jr Ragelia A. Silva	Present	Present
MCLEAN OHIO UNION WEBSTER	Wallis N. Bell	.....	.....

THIRD DISTRICT

		First Meeting	Second Meeting
CALDWELL CHRISTIAN	Ralph L. Cash, Jr Emmanuel J. Battah Harry J. Dempsey J. Nicholas Terhune	.....	.....
CRITTENDEN HOPKINS	Wallace R. Alexander James M. Bowles Udaykant V. Dave Tristan K. Lineberry Steve Hiland	Present	Present
LYON MUHLENBERG TODD TRIGG	Hank Bell, Jr	.....	.....

FOURTH DISTRICT

		First Meeting	Second Meeting
BRECKINRIDGE BULLITT GRAYSON GREEN HARDIN-LARUE	James R. Cundiff, Jr Ray A. Cave Nga T. Nguyen Callard David Anh Duy Daa Marian A. Dauglass, Jr Lavagilda Garcia Evelyn E. Salisbury Jahn W. Ratliff Raymond L. Mathis	Present	Present
HART MARION MEADE NELSON TAYLOR WASHINGTON	Eugene H. Shively Charles D. Haward	Present	Present

FIFTH DISTRICT

JEFFERSON

David T. Allen	Present	Present
Susan M. Berberich	.....	Present
Charles J. Bisig, Jr	Present	Present
David H. Bizat	Present	Present
Dwight L. Blackburn	Present	.....
Susan Barnstein	.....	Present
Mark H. Branner	.....	Present
Philip T. Brawne	.....	.....
William C. Buschemeyer, Jr	.....	Present
David E. Bybee	Present	Present
Peter C. Campbell	.....	Present
W. Neville Caudill	.....	Present
Gregory J. Ciliberti	.....	.....
J. William Camer	.....	Present
Jahn H. Dayle	Present	Present
Rudy J. Ellis, Jr	.....	Present
Samuel G. Eubanks, Jr	Present	Present
Jahn M. Farmer	.....	Present
Marijorie R. Fitzgerald	.....	.....
Beverly M. Gaines	Present	Present
Tani Michelle Ganzel	.....	.....
Henry D. Garretsan	.....	.....
Katherine P. Garrison	Present	Present
Kamla Gauri	Present	.....
Darius Ghazi	.....	Present
Linda Gleis	.....	Present
Larry P. Griffin	.....	.....
Harald D. Haller	Present	Present
B. Thomas Harter, Jr	.....	.....
Walter I. Hume, Jr	Present	Present
Barbara Sue Isaacs	Present	Present
Clifford V. Jennings	.....	Present
Jahn Jurige, Jr	.....	.....
Jahn M. Kariba	.....	Present
Arthur H. Keeney	Present	Present
Virginia T. Keeney	Present	Present
Danald R. Kmetz	.....	Present
Joseph E. Kutz	Present	Present
Robert W. Linker, III	.....	.....
Charles F. Mahl	.....	Present
Ralph Marris	.....	Present
Syed Nawab	.....	Present
Catherine Newton	.....	.....
Robert L. Nald	.....	Present
Charles R. Oberst	.....	.....
Habert L. Pence	.....	Present
James E. Redman	Present	Present
K. Thomas Reichard	Present	Present
William M. Renda	Present	Present
George R. Schrod	.....	.....
Edward L. Scafield	Present	Present
Kerry L. Shart	.....	Present
Wm. C. Templeton	.....	.....
Robert S. Tillet	.....	Present
Daniel W. Varga	.....	Present
Stephanie P. Waltan	.....	Present
Nartan Waterman	.....	Present
David R. Watkins	.....	Present
Thomas R. Watson	.....	Present
Peter H. Wayne, III	.....	.....
Samuel D. Weakley	Present	Present
Barbara Weakley-Janes	.....	Present
A. Franklin White, Jr	Present	Present
Fred A. Williams, Jr	Present	Present
C. Milian Young, III	.....	Present

SIXTH DISTRICT

ADAIR	Oris Aaran	.....	Present
ALLEN	Earl P. Oliver	Present	Present
BARREN	Ray A. Gibsan	.....	.....
	Marris David Mass	.....	.....
BUTLER			
CUMBERLAND	Samuel Lee Rice	.....	.....
EDMONSON	Omkar N. Bhatt	.....	.....
LOGAN			
METCALFE	Lawrence P. Embertan	.....	.....
MONROE			
SIMPSON	Michael Pulliam	Present	Present
WARREN	Craig Alvin Beard	.....	.....
	Jane R. Bramham	.....	Present
	Robert Emslie	.....	Present
	Jahn D. Gaver	Present	.....
	Paul J. Parks	Present	Present

SEVENTH DISTRICT

ANDERSON	Kenneth H. McCracklin	.....	Present
CARROLL	James Fetter, III	.....	Present
FRANKLIN	William H. Keller	Present	Present
	Jahn M. Patterson	Present	Present
	Benjamin Kutnicki	.....	Present
GALLATIN			
GRANT	David W. Wallace	.....	.....
HENRY	M. Brooks Jackson, II	.....	Present
OLDHAM			
OWEN	Jeffrey N. Sharpe	.....	Present
SHELBY	William K. Skaggs	.....	.....
SPENCER	Raderick H. MacGregar	.....	.....
TRIMBLE			

EIGHTH DISTRICT

BOONE	Les Hess	.....	Present
	Michael L. Rabinsan	.....	Present
CAMPBELL	Michelle M. Murray	.....	.....
	Frederick Stine	.....	Present
	Steven M. Waadruff	Present	Present
KENTON	Charles F. Allnutt	.....	.....
	Jahn Franklin Allnutt	Present	Present
	Elbert D. Baldridge, Jr	.....	Present
	Thomas E. Bunnell	Present	Present
	Joseph C. Martin	.....	Present
	Rass McHenry	.....	Present
	George E. Miller	.....	.....
	Theadore H. Miller	Present	Present
	Jackson O. Pemberton	Present	Present
	B. Robert Schwartz	.....	Present

NINTH DISTRICT

BATH	Emmett Lee Tate	.....	.....
BOURBON			
BRACKEN	Glenn R. Wamack	.....	.....
FLEMING	Danald R. Stephens	Present	Present
HARRISON			
MASON			
NICHOLAS	Robert L. McKenney	Present	Present
PENDLETON			
ROBERTSON	James C. Cantrill	.....	.....
SCOTT			

TENTH DISTRICT

FAYETTE

James W. Baker	Present	Present
James R. Bean	Present	Present
John V. Barders	Present	Present
Jahn W. Collins	Present	Present
Max A. Crocker	Present	Present
John D. Cranin	.....	Present
Elvis S. Donaldson, Jr	.....	Present
John M. Fax	.....	Present
W. Jeffrey Foxx	Present	.....
Michael D. Hogen	Present	Present
Bill H. Harris	Present	Present
Robert J. Homm	.....	.....
Dennis B. Kelly	Present	Present
Daniel E. Kenady, Sr	Present	Present
William D. Medina	Present	Present
Jahn M. Moore	Present	Present
Andrew M. Maare, II	Present	Present
Franklin B. Moosnick	Present	Present
Barbara A. Phillips	Present	.....
Jahn W. Paundstane	Present	Present
Andrew R. Pulita	Present	Present
Barry N. Purdam	.....	Present
John D. Stewart	Present	Present
John Robert White	Present	Present
Emery A. Wilson	.....	Present
William O. Witt	Present	Present

ELEVENTH DISTRICT

CLARK
ESTILL
JACKSON
LEE
MADISON

James B. Noble	*****	*****
G. Irene Minor	Present	Present
Richard A. Stane	Present	Present

MENIFEE
MONTGOMERY
OWSLEY
POWELL
WOLFE

Walloce L. Post, Jr	Present
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TWELFTH DISTRICT

BOYLE
CASEY
CLINTON
GARRARD
LINCOLN
MCCREARY
MERCER
PULASKI

David C. Liebschutz	Present	Present
Scott B. Scutchfield	Present	Present
Lewis E. Wesley	.....	.....
William C. Powell	.....	.....
Paul J. Sides	Present	Present
George W. Nae	Present	Present
Donald E. Brawn	Present	Present
James D. Crose	Present	Present
Joseph G. Weigel	Present	Present

ROCKCASTLE
RUSSELL
WAYNE

William D. Dooley	Present	
H. Michael Oghia	Present	Present
Jahn W. Simmans	Present	Present

THIRTEENTH DISTRICT

BOYD

Kenneth R. Hauswold	.....	Present
Haward B. McWharter	Present	Present
Mourice J. Oakley	Present	Present
Susan H. Prosher	.....	Present

CARTER
ELLIOTT
GREENUP

Jahn O. Jones	.....	.....
Laurent B. Tigas	.....	.....
George P. Carter	Present	Present

LAWRENCE
LEWIS
MORGAN
ROWAN

George R. Bellamy	.....	.....
Danald E. Blair	Present	.....
Marc L. Halbrook	.....	Present

FOURTEENTH DISTRICT

BREATHITT
FLOYD

Nicholas R. Jurich
Juan J. Ortiz

JOHNSON
KNOTT
LETCHER
MAGOFFIN
MARTIN
PERRY
PIKE

Mitchell Wicker, Jr	.....	.....
Somuel J. King	.....	Present
Roghurom Modur	Present	.....
Elster D. Raberts	.....	Present
Vivente B. Santelices	Present	Present

FIFTEENTH DISTRICT

BELL
CLAY
HARLAN

Iro F. Wheeler	.....	.....
John D. Miller	.....	Present
F. Andrew Morfesis	Present	Present
Ragelia A. Acasta	Present	.....
Stephen K. Taadvine	.....	Present
David W. Douglas	Present	Present

KNOX

LAUREL
LESLIE
WHITLEY

KMA Resident Physicians Section—Vincent P. Tonomochi	Present	.....
KMA Resident Physicians Section—Baretta R. Casey	.....	Present
U of K Student Delegate—Mark Cannan	Present	.....
U of L Student Delegate—David Verst	.....	Present
KMA-HMSS—William D. Prott	Present	Present

The information in the Roll Call was taken from the attendance record cards signed by the delegates prior to the meetings of the House, September 14 and September 16.

KMA's 142nd Annual Meeting



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(L to R) Reference Committee 1: John D. Noonan, MD, Paducah; Howard B. McWhorter, MD, Ashland, Chairman; H. Michael Oghia, MD, Russell Springs; Scott B. Scutchfield, MD, Danville; John V. Borders, MD, Lexington.



Reference Committee 2: Michael D. Hagen, MD, Lexington; Charles E. Bea, MD, Mayfield; Samuel G. Eubanks, Jr, MD, Louisville, Chairman; John D. Gover, MD, Bowling Green; G. Irene Minor, MD, Berea.



Reference Committee 3: David H. Bizot, MD, Louisville; Andrew M. Moore, II, MD, Lexington, Chairman; William D. Pratt, MD, London; Jackson D. Pemberton, Jr, MD, Hebron.



Reference Committee 4: John M. Patterson, MD, Frankfort; David W. Douglas, MD, London; K. Thomas Reichard, MD, Louisville, Chairman; Daniel E. Kenady, MD, Lexington; Harry W. Carloss, MD, Paducah.



Reference Committee 5: Jane R. Bramham, MD, Bowling Green, Chairman; John F. Allnutt, MD, Crescent Springs; Beverly M. Gaines, MD, Louisville; Elvis S. Donaldson, Jr, MD, Lexington; James D. Crase, MD, Somerset.



Reference Committee 6: Barbara A. Phillips, MD, Lexington; Frank K. Sewell, Jr, MD, Henderson; John W. Collins, MD, Lexington, Chairman; C. Milton Young, III, MD, Louisville; Thomas M. Gadiant, MD, Henderson.

The David Ottawa Hancock, MD Memorial Meeting of the Kentucky Medical Association

**Digest of Proceedings of the Regular Session of the*

House of Delegates

Danny M. Clark, MD, Somerset
Speaker of the House, Presiding

First Meeting September 14, 1992

Danny M. Clark, MD, Speaker of the KMA House of Delegates, called the first Meeting of the 142nd Session of House of Delegates to order at 9:00 AM on Monday, September 14, 1992, at the Hyatt Regency Hotel, Louisville, Kentucky. He introduced the Vice Speaker, C. Kenneth Peters, MD, Jeffersonton, and KMA's Legal Counsel, Charles J. Cronan, IV, Louisville.

Following the invocation given by Albert H. Joslin, MD, Owensboro, the Chairman of the Credentials Committee, C. R. Dodds, MD, Earlington, reported that a quorum was present. It was noted that James M. Bowles, MD, Madisonville, also served on the Credentials Committee.

A motion was made, seconded, and carried to approve the Minutes of the 1991 Session of the House of Delegates as published in the December 1991 *Journal of the Kentucky Medical Association*.

William P. VonderHaar, MD, Louisville, Secretary-Treasurer, announced that the Scientific Session would begin at 8:50 AM on Tuesday, September 15, and the President's Luncheon would be held on Wednesday, September 16, at which time the new President would be installed. Dr VonderHaar reminded the Delegates that Reference Committees would convene at 1:30 PM on Monday. He then asked the House members to stand for a moment of silence in memory of KMA members who had died since the 1991 Annual Meeting.

Speaker Clark announced that the Rules Committee had prepared a booklet outlining the rules the House should follow in its deliberations.

Pam Blackstone, immediate past president of the Auxiliary to

KMA, presented AMA-ERF checks comprised of funds the Auxiliary had raised to benefit Kentucky's medical schools. Carol Elam, Assistant Dean for Admissions, accepted a check in the amount of \$14,148.81 on behalf of the University of Kentucky College of Medicine; and Alfred L. Thompson, MD, Associate Vice President for Hospital Affairs, accepted a check for \$33,718.95 on behalf of the University of Louisville School of Medicine.

Speaker Clark noted that three special Resolutions had been introduced. The Resolutions were read, and a motion was made, seconded, and carried to adopt each as written:

RESOLUTION

In Memoriam — David A. Hull, MD **Board of Trustees**

WHEREAS, it is with deep regret that this House of Delegates notes the passing of David A. Hull, MD; and

WHEREAS, David A. Hull, MD, served this Association and the medical profession ably and with distinction as President, Chairman of the Board of Trustees, President of the Kentucky Foundation for Medical Care, and Trustee, and in other offices; and

WHEREAS, Doctor Hull provided steadfast leadership to this organization on several critical issues including peer review, continuing medical education, socioeconomic matters, and others; and

WHEREAS, Doctor Hull culminated his distinguished career with public service as coroner of Lexington-Fayette County; now therefore be it

RESOLVED, that the House of Delegates of the Kentucky Medical Association does pay tribute in memoriam to the notable service, loyalty, and dedication to medicine by David A. Hull, MD; and be it further

RESOLVED, that Doctor Hull's achievement and legacy of selfless contributions serve as a hallmark and guide for all physicians.

***Editorial Note: A tape recording was made of the two meetings of the House of Delegates, and any member who wishes to examine the transcript of these Proceedings may visit the Headquarters Office and listen to the recordings.**

RESOLUTION

Tribute to Will W. Ward, Jr, MD Board of Trustees

WHEREAS, Will W. Ward, Jr, MD, Louisville, has served the profession in this state with distinction and honor; and

WHEREAS, this service has been applied in various capacities at both the local and state levels; and

WHEREAS, Will W. Ward, Jr, MD, has applied his talents and counsel to the Judicial Council for eight years and has acted as Chairman of that Council for the past three years; and

WHEREAS, his tenure with that body ends this year after selfless and often arduous efforts on behalf of the Association; now therefore be it

RESOLVED, that the House of Delegates pays special tribute to Will W. Ward, Jr, MD, for his unselfish devotion and outstanding services to this Association; and be it further

RESOLVED, that this expression of gratitude and esteem for Will W. Ward, Jr, MD, be made a permanent part of the record of the House of Delegates and a copy be personally presented to Dr Ward.

RESOLUTION

Tribute to Leah Dickstein, MD Jane R. Bramham, MD, President Kentucky Branch, American Medical Women's Association

WHEREAS, Leah Joan Dickstein received her Doctor of Medicine Degree from the University of Louisville in 1970 and completed her residency in Psychiatry at the University affiliated hospitals; and

WHEREAS, Doctor Dickstein has, since 1975, been a member of the faculty of the University of Louisville School of Medicine, serving from 1981 to 1987 as Associate Dean of Student Affairs, and since 1989 as Associate Dean for Faculty and Student Advocacy; and

WHEREAS, Doctor Dickstein has been active in the Jefferson County Medical Society, currently serving as the Associate Editor of *Louisville Medicine*, as well as serving on other committees and being a member of the Kentucky Medical Association; and

WHEREAS, Doctor Dickstein has made extensive contributions by her teaching responsibilities and participation in nationwide medical organizations; and

WHEREAS, Doctor Dickstein has been elected to the Presidency of the American Medical Women's Association, which term of office begins in November of 1992; now therefore be it

RESOLVED, that the House of Delegates of the Kentucky Medical Association honor Doctor Leah J. Dickstein on the occasion of her inauguration as President of the American Medical Women's Association.

Speaker Clark introduced the officers who presented their Reports. Each of the Reports was assigned to a Reference Committee as noted:

Report Number		Reference Committee
1	Report of the President S. Randolph Scheen, MD, Louisville	1
2	Report of the President, Auxiliary to KMA Pam Blackstone, Owensboro	1
3	Report of the President-Elect William B. Monnig, MD, Edgewood	1
4	Report of the Speakers, House of Delegates Danny M. Clark, MD, Somerset C. Kenneth Peters, MD, Jeffersonton	1

Report Number		Reference Committee
5	Report of the Chairman, Board of Trustees Russell L. Travis, MD, Lexington	1
	Report of the Ad Hoc Committee on DNR James R. Bean, MD, Lexington	3
6	Report of the Secretary-Treasurer William P. Vonderhaar, MD, Louisville	1
7	Report of the Editor A. Evan Overstreet, MD, Louisville	1
8	Report of the Delegates to AMA Donald C. Barton, MD, Corbin	1
9	Report of the Executive Vice President Robert G. Cox, Louisville	1
10	Kentucky Physicians Care Operating Committee Russell L. Travis, MD, Lexington	1
11	KMA Physicians Services, Inc. Russell L. Travis, MD, Lexington	1
12	Kentucky Medical Insurance Company Richard F. Hensch, MD, Lexington	1
13	Scientific Program Committee Sonia R. Teller, MD, Louisville	2
14	Scientific Exhibits Committee Richard A. Kiehl, MD, Lexington	2
15	Continuing Medical Education Committee Larry P. Griffin, MD, Louisville	2
16	Council for Continuing Medical Education W. David Hager, MD, Lexington	2
17	Cancer Committee Clinton C. Cook, III, MD, Louisville	2
18	Physician Manpower Committee Robert R. Goodin, MD, Louisville	2
19	Hospital Medical Staff Section Donald J. Swikert, MD, Florence	2
20	Maternal Mortality Study Committee John W. Greene, Jr, MD, Lexington	3
21	Committee on National Legislative Activities Donald C. Barton, MD, Corbin	3
22	Committee on State Legislative Activities Wally O. Montgomery, MD, Paducah	3
23	Committee on Professional Liability Insurance Wally O. Montgomery, MD, Paducah	3
24	Committee on Impaired Physicians Burns M. Brady, MD, Louisville	3
25	Committee on Care for the Elderly John C. Wright, II, MD, Louisville	3
26	Committee on Medical Insurance and Prepayment Plans Donald R. Neel, MD, Owensboro	4
27	Committee on Claims and Utilization Review K. Thomas Reichard, MD, Louisville	4
28	PRO Advisory Committee James M. Bowles, MD, Madisonville	4
29	Committee to Investigate Changing Trends in Medicine Robert R. Goodin, MD, Louisville	4
30	Committee on Maternal and Child Health J. Gregory Cooper, MD, Cynthiana	5
31	Technical Advisory Committee on Physician Services (Title XIX) Harold L. Bushey, MD, Barbourville	5
32	Committee on Community and Rural Health Ardis D. Hoven, MD, Lexington	5
33	Committee on School Health, Physical Education, and Medical Aspects of Sports R. Quin Bailey, MD, Danville	5
34	Judicial Council Will W. Ward, MD, Louisville	6

35	Rural Kentucky Medical Scholarship Fund	6
	Donald R. Stephens, MD, Cynthiana	
36	Physician-Attorney Liaison Committee	6
	Lynn L. Ogden, MD, Louisville	
37	Membership Committee	6
	Harold D. Haller, Sr, MD, Louisville	
38	Young Physicians Steering Committee	6
	J. Gregory Cooper, MD, Cynthiana	
39	Medical Student Section	6
	Matt Shotwell, Lexington	
40	Resident Physicians Section	6
	Sheryl Schneider, MD, Louisville	
41	Ephraim McDowell Cambus-Kenneth Foundation	6
	S. Randolph Scheen, MD, Louisville	

New Business

New Business of the House was assigned to the Reference Committee indicated:

Resolution	Submitted By	Subject	Reference Committee
A	Fayette County Medical Society	Funding of Health Care in Kentucky	1
B	Board of Trustees	Health Care Reform	1
C	Board of Trustees	The Role of Organized Medicine in Health Care Policy	1
D	Board of Trustees	Deleterious Effects of Tobacco Use	2
E	Board of Trustees	Primary Care Preceptorships	2
F	Floyd County Medical Society	School Health Clinics	5
G	Floyd County Medical Society	Family Violence	5
H	Floyd County Medical Society	Medication Labeling	4
I	C. Dale Brown, MD, Paducah	Hospital Medical Staff Bylaws	2
J	Board of Trustees	Mandatory Continuing Medical Education	2
K	KMA Resident Physicians Section	Survey of Physicians Who Leave Kentucky	2
L	KMA Resident Physicians Section	Mandated Service Requirement for Kentucky-Trained Physicians	3
M	KMA Resident Physicians Section	Designation of Psychiatry as Primary Care for RKMSF	6
N	Northern Kentucky Medical Society Inc	Education of Students on the Hazards of Ultraviolet Radiation (Tanning Rays)	4
O	Fayette County Medical Society	Excise Tax on Tobacco Products and Discounts for Nonsmokers	3
P	Fayette County Medical Society	Restrictions on Smoking	3
Q	J. Gregory Cooper, MD, Chairman Young Physicians Steering Committee	Tax-Free Income for Services to Medicare/Medicaid Patients	5
R	Board of Trustees	Advanced Registered Nurse Practitioner (ARNP) Prescribing Privileges	6
S	Board of Trustees	Family Violence	5
T	Board of Trustees	Increasing the Number of Primary Care Physicians	2
U	Board of Trustees	Change of Rules of Order	1

Vice Speaker Peters announced the meeting locations for the Nominating Committee and for Trustee Districts electing Trustees and Alternate Trustees. He reminded the Delegates that the Nominating Committee would report at the close of the first Scientific Session on Tuesday morning.

The names of the Nominating Committee members were announced: John D. Noonan, MD, Paducah, Chairman; J. William Comer, MD, Louisville; Kenneth R. Hauswald, MD, Ashland; Dennis B. Kelley, MD, Lexington; and G. Irene Minor, MD, Berea.

Dr Peters adjourned the first meeting at 9:30 AM. He noted that at 10:00 AM, President Scheen would moderate a special panel to discuss health care reform, comprised of Leonard E. Heller, PhD, Secretary for Human Resources and Chairman, Commission on Health Care Reform; Senator Michael R. Maloney, Chairman, Senate Committee on Appropriations and Revenue; and Russell L. Travis, MD, Chairman of the KMA Board of Trustees.

Second Meeting September 16, 1992

Speaker Clark called the second meeting of the 1992 Session of the KMA House of Delegates to order at 7:00 PM on Wednesday, September 16, 1992. Paul J. Parks, MD, Bowling Green, gave the Invocation, and C. R. Dodds, MD, Earlington, Chairman of the Credentials Committee, reported that a quorum was present. Dr Clark noted that Baretta Casey, MD, Madisonville; Max A. Crocker, MD, Lexington; and R. J. Phillips, Jr, MD, Gilbertsville; would serve as Tellers during the Meeting.

Secretary-Treasurer Vonderhaar recognized guests from neighboring state medical associations who had attended the Annual Meeting. Included were C. Dyke Egnatz, MD, President, Indiana State Medical Association; Robert P. Pulliam, MD, President, West Virginia State Medical Association; Arvind K. Goyal, MD, President, Illinois State Medical Society; John W. Hollowell, MD, President, Medical Society of Virginia; and Stanley J. Lucas, MD, President, Ohio State Medical Association.

Russell L. Travis, MD, Chairman of the Board of Trustees, made a motion, on behalf of the Board, that Samuel D. Weakley, MD, Louisville, be elected to a four-year term on the Judicial Council. The motion was seconded from the floor and carried.

President Scheen then introduced the Governor of the Commonwealth of Kentucky, Brereton C. Jones, who had asked to address the House of Delegates. Governor Jones stated that he shared the commitment of Kentucky physicians to solve the problem of rapidly escalating health costs, and to ensure that all Kentuckians have health insurance coverage. Governor Jones advised the Delegates that it was his intention for the Kentucky General Assembly to convene in special session to enact a plan to reform the delivery of health care in Kentucky. The Governor stated that he realized the draft plan he had presented still needed changes, and he asked the help of physicians in designing a health care plan that would be the finest and most comprehensive in the country.

The Governor thanked the physicians for the help they have given to thousands of patients who receive medical care without charge because of their inability to pay, and asked them to rise to a higher level to show the country what could be done if Kentucky takes a leadership position to ensure that every citizen receives quality care health and fair and equal treatment.

Speaker Clark thanked Governor Jones for his comments, and assured him that Kentucky physicians would continue to do whatever they could to care for their patients.

The Speaker then called for the Chairpersons of the Reference Committees to present their Reports.

Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE NO. 1

Howard B. McWhorter, MD, Ashland, Chairman

1. Report of the President
2. Report of the President, Auxiliary
3. Report of the President-Elect
4. Report of the Speakers, House of Delegates
5. Report of the Chairman, Board of Trustees, *except* for the following:
Report of the Ad Hoc Committee to Implement Resolution M (1991)
(Referred to Reference Committee No. 3)
6. Report of the Secretary-Treasurer
7. Report of the Editor
8. Report of the Delegates to AMA
9. Report of the Executive Vice President
10. Report of KMA Physicians Care Operating Committee
11. Report of KMA Physicians Services, Inc
12. Report of the Kentucky Medical Insurance Company
Resolution A — Funding of Health Care in Kentucky
(Fayette County Medical Society)
Resolution B — Health Care Reform
(Board of Trustees)
Resolution C — The Role of Organized Medicine in Health Care Policy
(Board of Trustees)
Resolution U — Change of Rules of Order
(Board of Trustees)

ITEMS FOR CONSENT

Reference Committee No. 1 reviewed the following items and recommends they be filed or adopted, as indicated, by consent of the House, without discussion:

2. Report of the President, Auxiliary — filed
 3. Report of the President-Elect — filed
 4. Report of the Speakers, House of Delegates — filed
 6. Report of the Secretary-Treasurer — filed
 7. Report of the Editor — filed
 8. Report of the Delegates to AMA — filed
 9. Report of the Executive Vice President — filed
 11. Report of KMA Physicians Services, Inc — filed
 12. Report of the Kentucky Medical Insurance Company — filed
- Mr Speaker, Reference Committee No. 1 recommends adoption of the Consent Calendar as a whole.

Report of the President, Auxiliary

The focus of the 1991-92 Auxiliary year was an emphasis on our "Connections." Auxilians throughout the Commonwealth benefited from the hopes and dreams of previous leaders and focused their efforts on improving the image of medicine, working together, showing our pride in medicine, promoting volunteerism, and emphasizing a commitment to providing quality health care to all Kentuckians. Through hard work and a commitment to our purposes, all of our AKMA Connections have been strengthened.

Our Connection to the Kentucky Medical Association was enhanced as Auxilians were kept informed of issues and focus areas of

the KMA. The KMA included Auxiliary representatives in legislative briefings prior to the Kentucky General Assembly and involved Auxilians in key areas affecting health care legislation. The program for the Auxiliary-sponsored "Day in Frankfort" was enhanced by the information provided by KMA representatives, and Auxilians continue to be active participants on the KMA Legislative Committee and the KEMPAC Board.

The support of the KMA and the positive promotion of the Auxiliary by the KMA leadership have been invaluable and have allowed the Auxiliary to continue to provide the membership with quality programs and projects.

The Auxiliary Connection to the AMA Auxiliary provided the opportunity to join with over 70,000 other members throughout the nation to promote health. Information provided by our national committee members helped our state chairmen distribute important data to our county leaders.

Leadership training was available for state officers and convention delegates at national meetings; and Confluence provided a special occasion for six of Kentucky's county presidents-elect to gather information to help them better serve their communities. County presidents-elect from Daviess, Fayette, Jefferson, Henderson, Hopkins, and McCracken Counties had the opportunity to travel to Chicago for Confluences I and II and to take advantage of special training provided by national officers and committee representatives.

The AKMA Connection to our county auxiliaries was our strongest Connection. The state auxiliary chairmen provided training through leadership conferences. The officers and chairmen also provided information and assistance to counties in their efforts to increase membership, to raise funds for AMA-ERF, to promote health and healthy lifestyles, and to stay informed of legislative activities. Other chairmen kept the members informed of the activities at McDowell House, of the needs of the Ronald McDonald Houses, of the purposes of the International Book Project, and of special projects involving Doctors' Day and Medical Heritage projects.

The AKMA Fall Board, Winter Board, and Spring Convention meetings gave all AKMA members an opportunity to share and celebrate the accomplishments of the organization on the state level. Business of the organization was transacted and training sessions held on topics that were pertinent to the organization were addressed.

The AMA Auxiliary Annual Meeting in June 1992 provided an opportunity to honor the accomplishments of our organization on the national level. The Auxiliary to the Kentucky Medical Association was pleased to receive recognition for an increase in membership. Our fundraising efforts for AMA-ERF were acknowledged as Boyd County received an award for second largest per capita contributions in the nation for \$192.76 per member. Kentucky total AMA-ERF contributions (including physician contributions) totaled \$56,456.33 — an outstanding commitment to medical education.

Our AKMA Connections to our medical societies, to the AMA Auxiliary, to our county auxiliaries, and to our communities have emphasized our commitment to promoting health and healthy lifestyles for all Kentuckians.

Pam Blackstone
AKMA President

Report of the President-Elect

It is my privilege to report to you as President-Elect. Although I have

had the honor of serving the Association for some years in other capacities, this office has provided me with a unique perspective to gain an even greater appreciation not only of our accomplishments but of the increasing difficulties we are being called on to face.

For many years, medical writers and medical journals have sounded strident notes about the major changes that were looming to confront medicine and the difficult challenges for which we must prepare. This year has seen the fruition of some of these challenges, and the issues to be faced are very real, very present, and very significant.

At no other time in the history of our profession, our country, and our state have there been forces that are more threatening because of their potential to create division. Resource-Based Relative Value Scales would seem to pit physicians whose work is procedural-based against those whose work is cognitive-based. The current state of the Worker's Compensation program negatively focuses attention on those segments of our profession most commonly called on to deal with most compensation claims. Self-referral issues seem to spotlight all physicians who have business interests in technological service modalities. Health care reform measures are causing all parts of society, including physicians, to take a close look at insurance availability and equity of benefits, potential taxation of providers, and government dominance in the dynamic of care availability. Finally, we are being called on to define our own roles in the context of medical care delivery as patients who are infected by the AIDS virus.

The resolution of these issues is not subject to easy or perhaps even desirable answers. We no longer are simply being asked to respond to questions being posed by society, but are being forced to react to questions directed to ourselves. It is perhaps trite to say that we must stand and work together. As individuals, it is only natural that we define our reaction to each of these measures in an individual manner. It is only human and appropriate that we consider our personal needs, goals, and responsibilities in coming to terms with these specters. However, from that base, a consensus must be developed.

As with all group functions, the singular dynamic is a majority voice. I suspect there is not a single issue that all of us would agree on completely; yet, once developed, a consensus on that issue must be supported by all. We simply don't have the luxury, nor is it realistic, to hope to achieve a completely satisfactory answer on all of these topics that will suit all of us. My pledge to you as President-Elect is to sincerely solicit all views on these matters and to represent a consensus on your behalf.

In my position this year as the President-Elect, I would like to be able to report that I have gained in knowledge and wisdom and the ability to be a better leader. I can't give these assurances, but I can affirm an increased awareness of the critical need to be better informed, to base decisions and directions on knowledge and the sincere commitments of others, and to pledge my very best efforts to our cause.

I would like to humbly acknowledge the efforts and thoughtful input of the Board members and officers this year, and would be remiss if I did not note the work of Randy Scheen for many, many years. His year as President culminates an incomparable leadership career for him, and I humbly acknowledge his countless contributions.

I would like to thank the House of Delegates and the membership for the trust you have placed in me.

William B. Monnig, MD
President-Elect

Report of the Speakers, House of Delegates

Your Speakers cordially invite you to the 142nd Annual Meeting of the Association, and urge your committed and sincere participation in all the matters of business that come before the House. Additional materials that were not mailed to you will be made available, and we urge you to give all these concerns close attention and relay them to your constituent members.

This year, the first session of the House of Delegates will meet at 9:00 AM, on Monday, September 14, and immediately upon the termination of that session, a special meeting will be held to address health care reform issues. We urge you to attend and take part in this new forum.

The issue of a change in the Rules of Order will be presented to you at this meeting, and we hope that you can act on it positively. The standard Rules of Order used by KMA (Sturgis) have been superseded, in our view, by Rules of Order established by James E. Davis, MD, former Speaker of the House of Delegates and Past President of the American Medical Association. We feel that these rules are more succinct and better suited to the conduct of the House.

Your Speakers will make every effort to present the business of the House to you in a simple and straightforward manner. To this end, great attention has been given to the appointment of Reference Committees. Any Delegate or individual member wishing to become involved in Reference Committees is urged to contact us for future consideration.

We look forward to a productive meeting, stand ready to provide to any individual or group of members our assistance, and seek any comments or suggestions you may have.

Danny M. Clark, MD
Speaker

C. Kenneth Peters, MD
Vice Speaker

Report of the Secretary-Treasurer

I am privileged to report to you as Secretary-Treasurer. If possible, the Association's activities have become more diverse and, at times, more hectic than in the past.

The Board was pleased to welcome as new Trustees this year Ronald E. Walldridge, MD, from Shelbyville, and Don R. Stephens, MD, of Cynthia. Both of these gentlemen are certainly not new to KMA involvement, and their presence and experience are welcome additions to the Board.

An important aspect of the Association's work is devoted to membership. KMA must maintain membership to be able to speak on behalf of the profession as a whole, and to be able to provide a continuous forum for professional interchange. As of June 30, the end of the fiscal year, membership for all categories was up by 231 individuals from last year. Each year considerable effort is spent on various membership activities. Not only must new members be solicited, but services must be refined and provided to continuing members.

This year saw an increase of 181 Active members; 8 In-training members; 20 Associate and Inactive members; and 22 members in dues-exempt categories. Dues-exempt categories include retired physicians, students, disabled members, members in hardship categories, and members in the military. Likewise, AMA membership increased this year by 128 physicians over last year. A debt of thanks is in order to the Membership Committee and, particularly, to staff for their work in this area.

Probably the main focus of the Association this year has been on gubernatorial and legislative attention to health care reform. Beginning in earnest with the termination of the 1992 session of the Kentucky Legislature, countless meetings, communications, analyses, and negotiations were conducted to deal with this issue. The Board members did yeomen's work in attending public hearings in each district held by the Governor's Task Force on Health Care Reform. Officers and staff followed up these undertakings with attendance at meetings of the Health Care Reform Commission, and conducted numerous meetings with individual legislators, representatives of other organizations, and other involved parties.

Considerable effort was expended in refining the KMA plan and in reviewing proposals put forth by other groups. As of this writing, the Commission's proposal for health care reform has not been published, but I can only foresee increased work to deal with this major influence on medical care and medical practice. All of these efforts will be culminated in a special session of the Legislature tentatively scheduled for November. It is not now known what impact the effect of any legislative leadership changes will have on this situation or if the session will actually occur in November, but efforts related to this issue occur daily.

The new headquarters location has been fully occupied and settled for an efficient work operation. Part of the plans related to the headquarters relocation involved long-term considerations for the operation of our Association. Throughout the year an ad hoc committee has been at work to consider future location options, which include maintaining the current leasing arrangement, new construction, or purchase and relocation to a different building. Financially, the headquarters relocation continues to be a sound move, and all reasonable steps are being taken to ensure that any future moves will be equally positive.

The other reports contained in this booklet will provide more detail on these and other issues, and I would urge your attention to them.

Finally, I would like to express my appreciation for the trust you have placed in me in allowing me to serve as Secretary-Treasurer.

William P. VonderHaar, MD
Secretary-Treasurer

Report of the Editor

The *Journal of the Kentucky Medical Association* exists to provide practical scientific information of interest to the membership of the Kentucky Medical Association. It strives to help meet the needs of each physician to maintain a general awareness of progress and change in medicine and is designed to aid the practicing physician in providing comprehensive care. The Editorial Board bases the contents of your flagship publication on the needs and interests of the practicing physician. We want to serve **you**, Kentucky's physicians. We're the only publication in an ideal position to focus on the entire state medical community. Your *Journal* represents a principal membership benefit. It helps to both recruit new members and retain current ones. It is a valuable publication.

The *Journal* had a banner year in 1991 — it was recipient of two **national** awards. A **first place** award was presented by the American Medical Writers Association for excellence in design and printing. Comments from the critique included "the magazine has a clean, modern design . . . presents a lot of text material in a very readable fashion . . . consistently designed and edited, with attention to detail . . . obvious that an excellent job is done by your Editorial Board and staff in supervising the publication." Also, for the second consecutive year, the *Journal* received an Honorable

Mention award in the prestigious Sandoz Pharmaceuticals competition, which is given for excellence in design and editorial content. I am extremely proud of these honors. They symbolize the direction of the *Journal*.

During 1991 the *Journal* featured 29 original scientific articles representing the efforts of 104 authors; 4 Grand Rounds contributions from the University of Kentucky and University of Louisville medical schools representing 13 authors; several socioeconomic articles; the entire proceedings of the 1991 KMA Annual Meeting; state and federal legislation updates; book reviews written with knowledge of the subject and the balanced judgement of Book Review Author Stephen Z. Smith, MD; Auxiliary updates; as well as numerous editorials and letters discussing medical issues of interest to our membership.

The *Journal* took an opportunity in its March issue to recognize the contributions of the many KMA physicians who were called to serve their country in Operation Desert Shield and Desert Storm — our members who succeeded in creating and maintaining a health-care system capable of offering comfort and care to American and allied military.

In order to maintain or improve the quality of our publication, our readers need to provide interesting and informative articles suitable for printing. The Editorial Board encourages the submission of original research, case studies, medical history, and diagnostic and therapeutic updates. The *Journal* also provides a medium whereby individuals not yet in the mainstream of medical-scientific writing can begin their first efforts at such writing — interns, residents, and younger faculty members. Your manuscripts are greatly appreciated. We also encourage your letters to the editor regarding not only the *Journal* but any topics pertaining to the Association or of concern to the medical community. Good ideas and thoughts need to be recognized. The *Journal* is, after all, **your** publication.

To maintain its prestige, the *Journal* must select for publication material which is new or current, well-written, accurate, has educational value, and is of sufficient interest and importance to the KMA membership. The Board must use its prerogative to question; criticize; assail that which is uncertain, unclear, or erroneous; and to sustain that which is true and beneficial. Manuscripts under consideration are subjected to review by each member of the Editorial Board. Contributions to the *Journal* continue to increase. There were 11 Board meetings during 1991, and of the 54 manuscripts reviewed, the Editors rejected 13, indicating a 24% rejection rate.

I would like to acknowledge and thank all of the members of the Editorial Board for their interest, talent, and energy: Doctors Daniel W. Varga, Scientific Editor; Stephen Z. Smith, Assistant Scientific Editor; and Jannice O. Aaron, Martha Keeney Heyburn, William P. Hoagland, and Milton F. Miller, Assistant Editors.

Your Editorial Board strives to produce the best product possible within its financial framework. We carefully monitor expenditures. Advertising revenues during the past year have not been as large as during previous years. This is in keeping with the general trend for most medical publications. At the present time, we are actively engaged in discussions designed to increase our advertising revenue.

Your comments, criticisms, and accolades concerning the *Journal* are being carefully reviewed and weighed. We constantly challenge ourselves to make your publication stronger. It is our sincere hope that the *Journal* is fulfilling your expectations and makes you proud to be a member of the Kentucky Medical Association.

A. Evan Overstreet, MD
Editor

Report of the Delegates to AMA

I am pleased to report to you on behalf of your Delegation to the AMA. Your Delegation has put in a lot of long hours and, hopefully, productive work in representing Kentucky physicians to our national organization.

It is important that all members be aware of the impact and influence that the AMA, through its House of Delegates, has on national issues and health care policy. In addition to mounting one of the most efficient and, in my view, effective national lobbying efforts, the AMA participates on nearly a daily basis with federal administrative agencies, executive policy making bodies, and other national organizations on behalf of patients and physicians. This participation, through individual AMA members, runs the gamut from revising the Medicare Resource-Based Relative Value Scale (RBRVS) payment system to supporting or opposing far-reaching legislation. All efforts of the AMA are directly stipulated by the House of Delegates or are based on policy established by the House.

At each of its two meetings during the year the House of Delegates contends with numerous reports and Resolutions whose content is more easily measured by the inch rather than the page. Each member of the Kentucky Delegation is assigned a portion of this material to become not only familiar with, but an expert on, and through the Reference Committee process and the House sessions, see to it that Kentucky physicians' views are expressed. It is my honor and privilege to serve with your Delegates, who are: Robert R. Goodin, MD, Louisville; Wally O. Montgomery, MD, Paducah; Harold L. Bushey, MD, Barbourville; and Alternate Delegates Donald J. Swikert, MD, Florence; Ardis D. Hoven, MD, Lexington; J. Gregory Cooper, MD, Cynthiana; and Bob M. DeWeese, MD, Louisville. Not only do these individuals comprise the Kentucky Delegation and serve as your direct representatives, but all have gained some measure of stature in their own right in the various areas of AMA House actions to which they are assigned.

The various issues addressed by the House were far too numerous to detail in this report, but I would like to briefly relate some matters considered this year. Of major concern was the issue of so-called "self-referral" by physicians. Previously, the Council on Ethical and Judicial Affairs had rendered an opinion strongly opposed to self-referral except under strict limitations, but the House took the position that it is appropriate for physicians to refer patients for services in which they have an ownership interest, with a provision that the patient be aware of this interest and potential conflict.

A number of items were considered relating to Medicare and the RBRVS payment system. Positions were confirmed to seek further support for legislation that has been introduced to relieve reductions in pay for new physicians, to reinstate payment for EKGs performed by physicians in offices, to revise the geographic cost index, and to revise the currently assigned RBRVS units.

In associated matters, the House strongly opposed expansion of an RBRVS-type system to private insurers, and considered a number of issues relating to penalties physicians suffer indirectly for nonelectronic billing to the Medicare program. The House also confirmed attempting to focus government attention on recognizing the administrative factor of costs when considering health care spending, and concern was expressed about a proposed payment method that would reimburse both physicians and hospitals for services to HMO patients.

Considerable discussion was held about a lack of physician input in the formulation of health care policy. This concern ran the gamut from federal legislative proposals to local managed care plan operations, and the House voted to form an ad hoc committee

to study the issue and recommend specific actions by organized medicine.

Considerable discussion was heard about the onerous provision of OSHA blood-borne pathogen regulations and the new Clinical Laboratory Improvement Act regulations. Increased cost to the system is inherent in both of these provisions, regardless of benefit. With regard to the CLIA regulations, the AMA has been directed to work to revise the laboratory categories and oppose unannounced inspections.

Quite a bit of discussion was held concerning HIV and physicians. Report BB of the Board of Trustees considered these matters in detail and suggested eight recommendations which the House adopted. The pertinent provisions were that infected physicians should report their status to the state health department or a local review committee, which would then determine appropriate medical activities the physicians should engage in. Further, physicians should voluntarily undergo testing if they pose a significant risk of transmission in their practice, and local review committees which oversee these matters should be protected from liability.

On a related matter, Report OO of the Board of Trustees noted the increasing incidence and high risk of clinical tuberculosis in HIV-infected individuals. The report called for increased government funding for treatment modalities and called on the profession to give more attention to high-risk populations. Obviously, the more notable population would be those who are HIV-infected.

There were numerous issues that were secondary, but still of concern. Some of these included confirmation of participation in CME for expanded hospital privileges; family violence issues; support for fetal tissue research; support of gender-neutral language in all publications; a policy that utilization review physicians be licensed in the state where claims originate; support for continuous update of practice parameters; model legislation on "Dispense as Written" prescriptions; and quite a bit of discussion about the National Practitioner Data Bank and a need to enhance confidentiality of its information.

It is the nature of organizations that probably few of the individuals that comprise them completely agree with all of the positions taken. However, the AMA House provides a fair and straightforward forum for the doctors of this country to establish a consensus and carry that consensus forward. On behalf of the Delegation, we are pleased to be a part of that undertaking and would like to express our humble appreciation for the opportunity to represent you.

Donald C. Barton, MD
Senior Delegate

Report of the Executive Vice President

This Association year has offered more challenges than any year in my memory. In the later part of 1991, officers and staff spent considerable time dealing with RBRVS. We made numerous visits and phone calls to our Congressional delegation and administration officials, and worked hand-in-glove with AMA. The final results of our work in the RBRVS controversy, while not a great success in terms of "winning or losing," did negate more onerous proposals and reductions in payment than originally proposed. Growing federal intervention by OSHA, CLIA, and other alterations in payment levels, restrictions, and regulating activities, compound the government's inroads into the practice of medicine.

At the same time we grappled with RBRVS, Senator Benny Ray Bailey proposed a 6% state tax on physicians' gross income and mandated participation in Medicare. We reacted by mailing the

news article to every physician in Kentucky and scheduled informational meetings throughout the state. Kentucky physicians responded in a positive manner by contacting their legislators, and successfully shortstopped Senator Bailey's proposal.

In January, we faced a restless Kentucky General Assembly with pressure from all sides, including labor, business, and advocacy groups to address health care costs and access. With an aroused KMA membership, we faced off with those forces who were in the mood to turn the system upside down.

Governor Jones announced that he would call a special session of the Kentucky General Assembly in November and, at the same time, appoint a 45-member task force to study the issues and define the problem. He also appointed a separate 12-member commission to draw up legislative drafts to be forwarded to the KGA. We were disappointed that the Governor failed to include a physician on the commission and relayed that message via correspondence and a personal visit. I won't bother you with a litany of events that transpired since then, but will tell you that officers and staff have done everything humanly possible to participate and project ourselves into this process.

Due to the enormity of the situation and the potential the special session could have on patient care and the practice of medicine, KMA recognized the necessity of obtaining outside public relations consultation. We contracted with the same firm which handled our 1988 campaign for tort reform.

Over the past several months we have developed packets for task force members, the commission appointees, various staff members in the administration, legislators, KMA Key Contacts, and developed brochures for physicians' offices. In addition, we have worked on various press releases and developed physician/public/legislative strategies.

Our lobbying staff has spent considerable time with legislative leadership and commission members while KMA's leadership met personally with the Governor and his key representatives on several occasions. In addition, we developed a strategy whereby we meet with anybody, anywhere, anytime. At this point, it is impossible to predict the final outcome or what they have in store for us. However, I can think of no time in the profession's history that demands more physician involvement in the legislative process.

This Association year marked the departure of Lillie R. Byrd, a KMA employee for 25 years. Both the Board of Trustees and staff had ceremonies honoring her service. We wish Mrs Byrd well in her retirement.

John R. (Jack) Kelly joined the Executive Staff this year as Executive Assistant. Jack's responsibilities include staffing various committees and managing several staff duties. Marsha Harrington, CPA, joined the staff as Controller. Marsha's background in accounting, auditing, and tax laws will be extremely helpful in the coming years. We are also pleased to announce the promotion of Diane Maxey to Manager of Membership Development. Diane has been with KMA for many years and will manage the Membership Department, conduct seminars, and staff Resident and Student Sections.

For the first time, KMA has surpassed 3,900 Active members which represents a 5% increase over 1991 membership. This increase was matched only one other time in the last 25 years, in 1982. Membership in the AMA, as well as all other categories of KMA membership, has also risen during 1992.

The intensity of the health care reform debate has been a contributing factor in the recent increase in KMA membership as more and more physicians see the importance of a unified voice for medicine. In addition, many of the recruitment programs begun in the late 1980s with medical students and residents are coming

to fruition as young physicians continue their membership in organized medicine when they establish practice. We will need the continued support of the entire membership in 1993 to maintain and further strengthen our voice for physicians statewide.

Kentucky Physicians Care remains an integral part of KMA and the results of the program bring great credit to the Association. KMA's space is limited and KMIC very graciously agreed to provide space for KPC and to give office space to the Impaired Physician Committee Chairman. The 2,300 Kentucky physicians, in particular the primary care physicians, have established a model for all states because of their willingness to do what is right. In Governor Jones' announcement for health care reform, he explicitly recognized these 2,300 physicians who serve the needy noting that, "their desire to serve comes from the heart — and not from the pocketbook."

We have been in our new office space for one year and staff has settled in very nicely. In accordance with Board direction, we are in the process of considering several future alternatives. We, of course, could remain in our present location following the initial four-year lease; search for a building site and erect a new building; or purchase or lease our existing structure. A joint ad hoc committee has been appointed by KMA/KMIC Boards to review these options and to consider the above-listed alternatives, including the possibility of joint ownership. Many of our Board and membership support KMA having ownership with a "permanent identity" and this is a consideration of the search committee.

KMA has historically operated on a five-year dues plan. We have had no dues increase for the past few years now and none is anticipated for probably another five years. We are pleased to be in this strong financial position. Our biggest financial transaction this year was receiving payment in full for the sale of our old headquarters building, and those funds are now in a Building Reserve Fund.

We are pleased with President and CEO Steve Salman's direction of KMIC and the cooperation and consultation with KMA officers and staff. KMA and KMIC staffs meet on a monthly basis sharing information and educating each other on the individual operations. This exercise is very helpful and in the long term benefits both parties.

KMA's committee structure has continued to operate in an extremely efficient manner. Over 40 committees meet at various times throughout the year and their work is reflected in the Reports Book. Often their hard work goes unnoticed, but it is truly the backbone of this organization. On many occasions, I have reminded anyone who would listen that a great many laws which protect the health and safety of patients and programs in many areas of medical care come directly from a KMA committee. One example is the hospital sign you see on our nation's interstate highway system. We salute the chairmen and members of the committees who give so much of their time and talents.

As noted earlier, the 1991-92 Association year has been a year of change. It also closes the chapter on President S. Randolph Scheen's year. Doctor Scheen's experience and patience this year have been "just what the doctor ordered." He has very effectively bridged the past with the future in terms of KMA leadership and has assisted us, through his intuition and experience, in avoiding several missteps which might not have been in KMA's best interest. He still has a year to go as Past President and we plan to use his experience and knowledge extensively. Doctor Scheen and his wife, Betty, have been a great credit to this Association and to the profession. They have represented us superbly and we thank them for their service and sacrifice.

The remaining officers, Executive Committee, and Board of

Trustees have given the total effort and their time has been productive for the Association. Secretary-Treasurer VonderHaar has learned early of the requirements of his office. He has accepted them more than willingly and performed superbly. Board Chairman Travis has had to face more challenges to medicine than perhaps any in our past. I have admired his knowledge, enthusiasm, commitment, and drive to successfully get the job done. He has done more for KMA than I have words to convey. I know it is at a personal sacrifice and want him to know of my admiration and gratitude. As President-Elect, Doctor Monnig has been in the thick of it all, too. As past Trustee and Board Chairman, we know he is well qualified to assume the Presidency, and we look forward to working with him in that capacity.

This has been a year requiring staff to work in the fast forward mode and I would be remiss not to mention my praise and gratitude for each of them. They are dedicated, they are experienced and knowledgeable, and they go the extra mile. I know they are tired, too, and I am grateful for all they do because it is often that extra mile they go that brings about success.

Thank you, again, for the opportunity to serve you. On behalf of the entire KMA staff, thank you for your strong support and participation in KMA activities. While the coming year may be difficult, we are confident that the quality of medical care will survive and that the voice of Kentucky physicians will be heard as changes, which we all know are inevitable, occur in the Commonwealth.

Robert G. Cox
Executive Vice President

Report of KMA Physicians Services, Inc

KMA Physicians Services, Inc, is the only wholly owned subsidiary of the Kentucky Medical Association, and serves as a holding company to its own subsidiary, the KMA Building Corporation.

The KMA Building Corporation was formed when we owned our own headquarters building. Its role was to collect rent and pay all bills relating to the most recent addition to that building, which was sold in 1991 to Hospice of Louisville, Inc.

It is anticipated that the Building Corporation will collect its share of the old KMA headquarters building sale proceeds, and transfer those funds via dividends to KMA's building fund for future use in the purchase or building of a new headquarters office. The Kentucky Medical Association is currently leasing space with a lease commitment until July 1, 1996.

It is further anticipated that there will be no additional activity for KMA Physicians Services, Inc, or for the Building Corporation in the immediate future, and the two corporations will be kept as paper organizations for future use as our needs might demand.

Russell L. Travis, MD
Chairman

Report of the Kentucky Medical Insurance Company

The Kentucky Medical Insurance Company has been experiencing an exciting year in 1992. Some of our major accomplishments during the first eight months of this year include:

- receiving an A.M. Best rating of A- (excellent);
- entering into a Letter of Intent to seek common ownership with similar companies in Ohio and Indiana;

- increasing our policyholder base by 4% compared to mid-year numbers in 1991;
- filing for licensure in Ohio;
- writing coverage for our first Tennessee hospital;
- continuing reduction in our expenses;
- and the successful implementation of our strategic plan.

We have changed in many ways since we were established by the KMA in 1978. And yet, ... we've basically stayed the same. While we have grown and improved dramatically, we are still the same company founded by the KMA in 1978 to serve Kentucky physicians.

During 1992, we've seen an increase in our policyholder numbers. At the end of July 1992, we were up by 4% compared to last July. This commitment from our insureds makes us extremely pleased and proud. The hospital division has experienced growth, too. In fact, since April of this year the hospital division wrote coverage for two institutions: the Frazier Rehab Center in Louisville and the Henry County Medical Center in Paris, Tennessee.

From a national standpoint, we are seeing a continued rise in claims frequency and severity. Indications show that this trend will continue and insurance premiums will begin to rise in most states. In fact, Departments of Insurance in several states are now considering rate increases. One large medical professional liability insurance company was recently granted permission to raise rates as much as 15% in Nebraska, 7% in Arizona, and 3% in Illinois. Another major carrier in Massachusetts plans a 14.1% increase if permission is granted from that state's Department of Insurance.

For the past two years, Kentucky Medical has given our physician insureds a claims experience credit of up to 25%. We plan to continue this program. In addition, our policyholders will continue to be eligible for a 5% premium credit if they attend one of our risk management seminars.

Financially, we remain strong and attentive to maintaining adequate reserves for future claims. In fact, we were recently recognized by A.M. Best (the prestigious insurance rating organization), who awarded us an A- (excellent) rating for our exceptional claims paying ability. This news was particularly gratifying since it came at a time when many other insurers were receiving a rating decrease from A.M. Best.

Through the second quarter of 1992, earnings were \$1,585,978, which was a slight increase from the same period in 1991. This increase is due to a larger policyholder base and corporate cost controls.

In July, Kentucky Medical announced its intent to enter into a business combination with two other physician-controlled insurers. Together, the three companies will seek common ownership through a holding company. If an agreement is consummated, all three companies expect to enjoy cost reductions through economies of scale, especially in areas such as reinsurance and portfolio management. The agreement does not mean Kentucky Medical Insurance Company will merge into some larger entity. The Company will remain in Kentucky and operate to serve the needs of Kentucky physicians.

Again, we appreciate the support and confidence of our policyholders and the KMA. With your help, Kentucky Medical is facing a dazzlingly bright future.

Richard F. Hench, MD
Chairman, Board of Directors

END OF CONSENT CALENDAR ITEMS

Report of the President

This will be my final report to you as the 141st President of the Kentucky Medical Association. When I was first elected to the office of Secretary some 25 years ago, I expected it to be a short-term appointment. I was privileged to be allowed to continue in that office and to serve you in that capacity over these past years. Being elected to serve as President has been, indeed, an honor and a privilege. I have represented you to the best of my abilities in all endeavors and trust that these endeavors will be beneficial and lasting for KMA.

In my inaugural address, I spoke of "Professionalism," or the Doctor-Patient relationship. I would like to again stress in this report the importance of this relationship and how it must be preserved and maintained. Professionalism is our very identity as physicians. The basis of professionalism is a doctor looking after a patient. We must be good, ethical professionals and we must preserve, protect, and promote this professionalism. As Doctor John Ring in his address to the AMA stated, "By Professionalism I mean that dedication to competence, compassion, and moral accountability that has characterized the best doctors in every era." Let nothing threaten our relationship with our patients — it is our most precious commodity. Through this relationship many things, both medical and societal, can be accomplished. Without this relationship we have lost our true identity.

As you all know, this year has primarily been devoted to many hours of work on health care reform. Your Quick Action Committee, Executive Committee, KMA staff, and KMA Board have met many times and developed our KMA health care reform recommendations for the Governor's Commission. These have been distributed to the membership by way of the "Communicator," so you should all be familiar with this plan. This is the major issue of the year, and I am sure will be discussed in other reports. We hope the Governor's Commission will utilize our recommendations in developing its program.

The Governor has called for a special legislative session to enact health care reform legislation this fall. KMA is fortunate to have Doctor Wally Montgomery, head of the Legislative Committee, and our legislative staff, who will be on site to monitor this legislative session and be available to assist our legislators with advice and information on KMA's recommendations on health care reform. This legislative session will be very important to physicians of the Commonwealth. Your KMA organization represents you at all societal levels and does it with many members who are nonparticipating. As I have stated before, at this time we need more than your dues — we need you to become involved. I would urge all physicians to get to know their legislators, become familiar with the legislation, and get involved. Only through a concerted or group effort will our voices be heard. Without your active involvement, someone else will solve these problems for us, and we may not be happy with their solutions.

During the past year I have attended meetings of our surrounding state medical organizations. As I attended these meetings, it was evident that we are all facing the same problems. All of these states are working on health care reform packages, and all are facing the same basic problems — how to improve access, reduce costs, and finance health care. Many of their recommendations parallel those of our own health care reform package. Another common theme of these state meetings is the emphasis on the importance of increasing membership, increasing involvement of members, and urging their membership to also join and become active in PACs. At this time, only 19% of our KMA members belong to KEMPAC. In times like these, this is a woefully small percentage.

The cost of KEMPAC membership is small compared to the benefits. I urge all members to join KEMPAC and to help them maintain and increase their campaign activities. We all must sacrifice, not to protect our income, but to preserve the finest medical care system in the world.

As a member of the Board and Treasurer of the KMIC, I am happy to report to you that your insurance company is doing well under the direction of our new CEO and President Steven Salman. As you know, he replaced Carl Wedekind who brought the company from one born in infancy in the malpractice crisis of the 1970s to a strong, solid malpractice insurance company. Our company has now received an (A-) Excellent rating, which is one only given to companies having a strong ability to meet their policyholders' and other contractual obligations over a long period of time. We are fortunate to have Steven Salman as our new President to lead our company to continued progress in the coming years.

I might remind you of the generosity of Mr and Mrs Joseph Wallace of Danville, who have directed in their will that their large farm, Cambus-Kenneth, in Danville be left to the McDowell Foundation. We have met a number of times with the Wallaces and their wishes were that since this farm was Ephraim McDowell's summer home, that it be left to the McDowell Foundation and the central portion of the farm be used for some medical purpose. I would like to express my appreciation for their generosity.

I would like to acknowledge my many friends and colleagues who have been supportive and most helpful during my years as Secretary and President. Their warm friendship and encouragement was of great help through all of these years.

This report would not be complete without a special vote of appreciation to Robert Cox, our Executive Vice President, and all of KMA's staff. Over the past 26 years I have worked almost on a daily basis with them. They work long hours with unselfish devotion to KMA's needs. Few people are aware of the amount of background work that goes into the everyday operations of KMA, the Annual Meeting, committee meetings, and Board meetings. Our staff is one we can rely on at all times and point to with pride. I can't thank them enough for their invaluable help to me during my terms as Secretary and President.

Our excellent secretarial staff also deserves our appreciation. They are efficient, always willing to work and dedicated to seeing that our work is done correctly and on time. We are fortunate to have such a fine staff of secretaries and extend our deep thanks to them.

It is with some sadness that I finish my term as President, but it is with great confidence that I turn the reins of leadership over to our new President, Doctor William Monnig. In his capable hands KMA will continue to even higher levels of accomplishment and newer achievements. All of my warmest thoughts will be with him.

Finally, I want to thank you for your confidence in allowing me to represent you as President of this Association. It has been an honor and a privilege to serve you. Good Bye!

**S. Randolph Scheen, MD
President**

Recommendations, Reference Committee 1:

Reference Committee No. 1 reviewed the Report of the President. The Committee would like to express sincere thanks and appreciation to Doctor Scheen for his exemplary service and devotion to the KMA for more than 25 years.

Reference Committee No. 1 recommends that the Report of the President be filed.

Report of the Chairman, Board of Trustees

As I complete a year's service as Chairman of your Board of Trustees, I find the past year very enlightening and perhaps quite frightening. Enlightening because I was astonished to see the time and energy given by physicians from across the state, and especially the Trustees and officers, on behalf of our profession. I've read about it in the past, but seeing it made a believer of me. It was enlightening to see so many thoroughly involved as we face health care reform in our state. It was also frightening to be involved on a day-to-day basis with so many individuals outside the profession with powers to change our health care delivery system, who had such limited and many times erroneous knowledge about what health care is truly all about.

This has been your Association's busiest year ever, and that is now a routine statement because every year turns out busier and more involved than the previous one. Representation is a prime benefit of your membership, and we have kept a high profile this year on behalf of the profession with government, third parties, the public, press, and to a greater extent with allied groups.

We have spent much time on the subject of AIDS, and increased our promotion of tort reform and easing of professional liability concerns. We've strengthened Health Care Access and our role in providing care to the indigent. We've worked daily with the Washington scene on such matters as Medicare, RBRVS, Disability Act, CLIA, and OSHA standards. We've been on the scene in Frankfort continually tending to matters about which I hope most of you are aware ... from AIDs ... to Workers Compensation. This was a legislative year which demanded an inordinate amount of time by your officers and many other dedicated physicians, as well as a special commitment by your staff.

The overriding subject with which we have dealt this year is health care reform. Nothing could have taken more from all of us than what we have put into this effort, individually and collectively. Meetings were held just about daily, and information was distributed continuously from KMA. Your officers are tired, your Executive Committee and Board members are tired, but we are all determined to see this issue to the very best conclusion possible. Our patients and the profession deserve our total commitment, and that is what we pledge to you. But this issue will also demand that every physician in this state direct his or her attention to health care reform, learn the issues completely, and relate our position to your legislators over and over again. We've made our promise at the leadership level. Will you make yours?

The Governor's Task Force on Health Care Reform has completed its work, and as I write this the Commission is conducting its business. More forums around the state are to follow, and then a Special Legislative Session will convene about six weeks after the House of Delegates' session. We have done a tremendous amount of work but much remains for us to do. A strong, united profession provides us with our best and maybe our only shot.

In the midst of all of the above, we just completed our first year in our new headquarters. We have four more years to lease in our current location. The sale of our old headquarters was completed last year, and we have now been paid in full for that sale with the funds invested in a building fund for use as we select a new headquarters home for the future. We have been extremely pleased with the sale of our building, the securing of all the funds for it, and the location and serviceability of our new location.

So it **was** our busiest year in history. I value the support and commitment of every member, and especially my fellow officers and members of the Board of Trustees. I believe the officers' and Board's actions have been worthy of pride and the accomplish-

ments have positioned us for the future. Thank you for the opportunity of serving as your Board Chairman.

A report on the Legal Trust Fund is included annually in the Chairman's Report. Expenditures were made during the past year of only \$96, and the Fund's balance is \$224,346.86.

The following summary of Board meetings is submitted to give you a quick view of your Board's activities. Complete Minutes of all Board meetings will be provided to Reference Committee No. 1. All of the committee reports give you additional insight into your associates' involvement on our behalf. I urge you to get behind your KMA. It is working for you every day of the year.

SUMMARY OF BOARD MEETINGS

First Meeting, October 3, 1991

Acting as temporary Chairman, KMA Secretary-Treasurer William P. VonderHaar, MD, introduced the newly elected members of the Board and the new officers: William B. Monnig, MD, Edgewood, President-Elect; Ardis D. Hoven, MD, Lexington, Vice President; Ronald E. Walldridge, MD, Shelbyville, Trustee, 7th District; Donald R. Stephens, MD, Trustee, 9th District; and J. Gregory Cooper, MD, Cynthiana, Alternate Delegate to AMA.

The Board elected the Executive Committee members to serve with the President, President-Elect, Vice President, and Secretary-Treasurer for the 1991-92 KMA year. Russell L. Travis, MD, Lexington, was elected Chairman of the Board, and Lucian Y. Moreman, II, MD, Elizabethtown, was reelected Vice Chairman. John W. McClellan, MD, Henderson, and William H. Mitchell, MD, Richmond, were named as Trustees-at-Large.

It was noted that the KMA Executive Committee members also serve as the Board of Directors of KMA Physicians Services, Inc (KMA's holding company). The Board also made changes to the Kentucky Foundation for Medical Care Board of Directors in accordance with KFMC's Bylaws, and appointed KMA committees for the following year. The Board voted to hold the 1992 Annual Meeting on September 15-17 at the Hyatt Regency Hotel in Louisville.

Second Meeting, December 18-19, 1991

Convening in a regular session, the KMA Board of Trustees held a two-day meeting on December 18 and 19. Oral reports were given, including those of the President, the Secretary-Treasurer, the Senior Delegate to AMA, the Dean of the University of Kentucky College of Medicine, the Commissioner for Health Services, Vice Chairman of the KMIC Board of Directors, and a member of the Board of Medical Licensure.

The Board members heard a detailed report on the status of the Medicaid Program, with specific emphasis on Senator Benny Ray Bailey's proposal to tax providers 6% of gross revenue. The Board expressed strong opposition to this concept, and staff outlined legislative activities relating to the Senator's proposed bill. The Director of the Medicare Part B Program, James B. Holloway, Jr, MD, also updated the Board members regarding changes in the Medicare Program, and packets of information containing details were distributed.

The Board members reviewed a slide presentation by Arthur Andersen & Co on *The Future of Healthcare: Physician and Hospital Relationships*, and discussed the results of a statewide survey on health care with a Senior Vice President of the Gallup Organization.

Representatives of Kentucky Blue Cross and Blue Shield made a presentation regarding the KMA-endorsed BCBS plan for the membership. The Board approved terms of the plan renewal, as recommended by the KMA Committee on Medical Insurance and Prepayment Plans.

Detailed reports were given concerning the activities of the Committees on National and State Legislative Activities, which included plans for the 1992 Kentucky General Assembly. Appointments were made to the KMIC Board Election Nominating Committee, and reports of the Membership Committee and the Kentucky Physicians Care Program were also accepted.

The Board took action on various matters, including submitting the name of Wally O. Montgomery, MD, Paducah, for appointment to the AMA Council on Legislation; approved action taken to implement directives of the 1991 House of Delegates; and endorsed a recommendation of the Executive Committee to submit details of the function of the KMA Committee on Claims and Utilization Review to the Department of Insurance in accordance with a recently enacted statute.

Third Meeting, April 15-16, 1992

The KMA Board of Trustees held its two-day Spring meeting on April 15 and 16, 1992, at the Radisson Hotel in Louisville. The Board members heard reports from the President, the Secretary-Treasurer, the Auxiliary President, the Senior Delegate to AMA, the Vice Dean of the University of Louisville School of Medicine, the Chairman of the KMIC Board of Directors, and the President of the Board of Medical Licensure.

The Board adopted a budget for the 1992-93 Association year, appointed three Board members to serve on a KMA/KMIC Liaison Committee, and approved implementation of a formalized Impaired Physicians Program with a full-time medical director.

The KMIC Board Election Nominating Committee, chaired by John W. McClellan, Jr, MD, submitted its nominees for KMIC Board positions. Steven L. Salman, Louisville, was subsequently appointed to the KMIC Board of Directors, and S. Randolph Scheen, MD, and Robert G. Cox, both of Louisville, were both reappointed.

The Board authorized the KMA Vice President to work with an infectious diseases consultant to produce an "OSHA Exposure Control Plan" to meet requirements of the Occupational Safety and Health Administration's Final Standard on Bloodborne Pathogens. The Board directed that the plan be made available to members at cost.

Reports of the Membership Committee and Cancer Committee were accepted, and comprehensive reports were given concerning the activities of the Committees on National and State Legislative Activities, which included details of the 1992 Kentucky General Assembly. The Chairman of the Committee on State Legislative Activities reviewed several subjects which have generated considerable controversy during the past several General Assemblies, including issues involving nurse practitioners, Certificate of Need for physicians' offices, and mandatory continuing medical education.

An ad hoc committee was authorized to meet with representatives of the Advanced Registered Nurse Practitioners to discuss matters of mutual concern, and its findings are expected to be presented to the House of Delegates in September. The CME Committee asked that the Board endorse the concept of mandatory continuing medical education, which the Board did, and requested that the CME Committee present details for such a proposal at the August Board meeting.

The KMA has endorsed the implementation and enforcement of the Certificate of Need law for hospitals, nursing homes, and various facilities and services. In addition, we have historically supported and successfully maintained the preservation of the private physician's office exemption from CON. The House of Delegates reaffirmed this position in 1990 through Resolution D. However, KMA's position relating to the purchase of equipment by private

physicians has become increasingly difficult and contradictory to defend, and has been characterized by members of the General Assembly and others as self-serving, and is perceived as a contributor to the rising cost of medical care. After careful review of our position, the Board of Trustees adopted the following statement and recommends to the House of Delegates that it concur with this revised policy:

Private offices and clinics of physicians and other practitioners of the healing arts should be exempt from CON requirements, including but not limited to, licensure, supervision, regulation, or control regulated by the Commission on Health Economics Control (CHEK), except as they propose to provide equipment which costs exceed \$250,000.

The Board spent considerable time discussing a KMA plan for health care reform to submit through the Task Force and Health Care Commission to the General Assembly. In doing so, the Board members reviewed various policies and positions of the Association which relate to the legislative process. An extensive KMA plan was adopted utilizing KMA House of Delegates policies which the Board members felt address issues which should be considered in any serious attempt at health care reform.

Recognizing that KMA would be required to deal with all phases of health delivery during the deliberations, the Board of Trustees authorized the KMA Quick Action Committee to represent the Association in all matters relating to the special Task Force, Commission, and Special Session. The Board also authorized the President to call emergency meetings of the Board and special sessions of the House if indicated. Realizing the need for professional assistance, the Board authorized KMA to contract with a public relations firm to assist the Association in devising various public, legislative, and membership strategies to prepare for the Special Session of the General Assembly planned for November 1992.

Fourth Meeting, August 5-6, 1992

The KMA Board of Trustees held its fourth meeting of the Association year on August 5-6, 1992, at the Hyatt Regency Hotel in Louisville. Reports were given by the President; Secretary-Treasurer; President, Auxiliary to KMA; Senior Delegate to AMA; and Chairman, Committee on State Legislative Activities. In addition, the Board heard presentations from representatives of the Kentucky Medical Insurance Company, the Board of Medical Licensure, the Director of the Medicare Part B Program in Kentucky, and the Chairman of the KMA CME Committee.

President Scheen presented a bound set of *Journals* to Immediate Past President Preston P. Nunneley, MD, which were published during his term as President. It was reported to the Board that Hospice of Louisville, Inc, had elected to pay off its note to KMA for the sale of the headquarters building on Ephraim McDowell Drive, and the funds had been invested in a building fund for a future home for the Association.

The Secretary of the Cabinet for Human Resources, Leonard Heller, PhD, attended the Board meeting to report on activities relating to health care reform, which was followed by a question and answer session. The Board members spent the remainder of the Wednesday evening session discussing the health care reform issue. Plans were discussed to hold a forum on this subject at the first meeting of the KMA House of Delegates on September 14, 1992, which would include Secretary Heller, a state legislator, and a KMA officer.

The Board reviewed its ad hoc committee reports, as well as each final committee report to be submitted to the 1992 House of Delegates. Several Resolutions were authorized for submission to

the House. A listing of actions taken to implement the directives of the 1991 House of Delegates was distributed, and it was noted that the same information would be sent to every Delegate as an addendum to the 1992 Board Chairman's Report.

The Board members expressed support for a letter of intent signed by the Kentucky Medical Insurance Company to form a holding company with the Physicians Insurance Companies of Ohio and Indiana, and endorsed the idea of a joint meeting of the KMA and KMIC Boards.

In other action, the Board authorized a \$10 voluntary assessment for the Legal Trust Fund to be included with the 1993 dues billing; appointed Albert H. Joslin, MD, Owensboro, to the KEMPAC Board of Directors; and concurred with the nomination of KMA Alternate Trustees to serve on a Medicare Physicians Advisory Committee. It was agreed to invite Alternate Trustees to attend the first meeting of the Board to be held during the Annual Meeting on Sunday, September 14.

Executive Committee

Eight Officers and Trustees comprise the KMA Executive Committee and four of these eight (President, President-Elect, Chairman of the Board, and Secretary-Treasurer) serve as the Quick Action Committee. The Executive Committee meets between sessions of the full Board to guide the day-to-day operations of the Association and to make recommendations on major matters coming before the Board requiring more extensive consideration. The Executive Committee met six times this year, and the topic of health care reform also dominated its agendas. Many physician hours of work go into these meetings.

Quick Action Committee

The Quick Action Committee meets "on call" to take care of the business at hand and met weekly during the January-April session of the Kentucky General Assembly. For these many legislative meetings this year we had Past President Preston Nunnelley, MD, joining the Quick Action Committee and Chairman of State Legislative Activities, Wally Montgomery, MD. Each of these meetings lasted 4-5 hours, followed by a late-night drive back home for all. You just can't get more dedicated than this group, and I appreciate them more than they'll ever know. I hope every KMA member shares that gratitude with me.

Ad Hoc Committees

The five ad hoc committees of the Board working this year were: the KMIC Board Nominating Committee; the Ad Hoc KMA/KMIC Board Liaison Committee; the Ad Hoc Committee on KMA/KMIC Headquarters Location; the Ad Hoc Committee to Implement Resolution M (1991) "Do Not Resuscitate;" and the KMA/KNA Subcommittee on Nurse Practitioners.

The KMIC Board Nominating Committee was chaired by John McClellan, Jr, MD, and its nominations and subsequent appointments are reported in the summary of the April 15-16 Board meeting on page 5.5 of this report.

The Ad Hoc KMA/KMIC Board Liaison Committee was established to determine what synergistic efforts can be made by KMA and KMIC that would help each fulfill its mission and reach its goals. Drs VonderHaar, Hoven, and Mitchell represent KMA on the Committee, and Drs Monnig, Wilkinson, and Steve Salman represent KMIC.

The first meeting of the Committee was held in July and a number of issues were addressed. The major recommendation coming from the meeting was that KMA and KMIC hold a joint Board retreat to better acquaint KMA's Board with current KMIC activities and to share comments, thoughts, and suggestions. The Committee

will meet on at least a quarterly basis and is working on several other ideas that will, hopefully, enhance the relationship of the two organizations, all of which would be to the advantage of the individual KMIC insured and KMA member. KMA is proud of KMIC and wants to work as closely as possible as the two organizations jointly serve the physicians of this state.

The Ad Hoc Committee on KMA/KMIC Headquarters Location is chaired by William B. Monnig, MD, and met a number of times. As reported last year, KMA sold its Headquarters Office in Louisville which had housed KMA staff since 1961, and the Kentucky Medical Insurance Company (KMIC) staff since KMIC's inception in 1979.

The growth of KMIC had put increasing pressure on space availability in the Headquarters Office, and after exploring every possible alternative, suitable space was located in adjacent buildings in Louisville's east end. While this space is satisfactory, it does have limitations for the staff, and the Boards of KMA and KMIC have established the goal of having both organizations housed in their own headquarters structure by 1996.

Your Committee continues to examine options that would put KMA and KMIC in an ownership position. The Committee is working with a realtor and has examined existing structures that could be purchased, as well as building sites that would accommodate a suitable headquarters building in a desirable locale.

The Ad Hoc Committee to Implement 1991 Resolution M (Do Not Resuscitate), chaired by James R. Bean, MD, was appointed to meet with all interested parties to develop the program approach to the terminally ill patient not desiring resuscitation or extraordinary life-prolonging treatment in the pre-hospital environment; to develop a standard DNR form and pursue acceptance of such; to seek legislative and regulatory changes to protect patients and health care professionals; and to develop a method to identify all patients with a valid DNR order. The complete report is attached as an addendum to this report.

The KMA/KNA Subcommittee on Nurse Practitioners met three times this year to discuss prescribing by advanced registered nurse practitioners (ARNPs). William P. VonderHaar, MD, Chairman; Preston P. Nunnelley, MD, and Jerry W. Martin, MD, were appointed to the Subcommittee. The Subcommittee has presented a proposal to the ARNPs which would provide joint oversight by the Medical Licensure and Nursing Boards. Details are being worked out to see if a solution can be found. Doctor VonderHaar and the members of the Subcommittee expect to have a full report or Resolution at the 1992 Annual Meeting.

In closing, I want to reiterate this has been a year like we have never seen. Yet while we have been sidetracked to handle many new and complex matters, much has been accomplished and we should all take pride in that. I again thank the membership, the committees, the Board of Trustees, and the House of Delegates for untiring efforts and support. This may have been our most challenging year since our inception in 1851. Next year will be more so.

I also want to thank each and every staff member, for it is with their dedication, continuity, total effort, and long, long hours that KMA and your leadership can make progress. Special note should also be made that our Executive Vice President, Robert G. Cox, has just completed 30 years of service to KMA. A large part of the success of this Association is due to Bob's dedication and leadership.

Our future is up for grabs. Our best hold can only come from a unified profession. With it, we can continue to be the appropriate advocate for our patients.

Russell L. Travis, MD
Chairman

RECOMMENDATION:

1. The Board of Trustees recommends that the House of Delegates concur with the following statement adopted by the Board of Trustees at its April 1992 meeting, which revises KMA policy: Private offices and clinics of physicians and other practitioners of the healing arts should be exempt from CON requirements, including but not limited to, licensure, supervision, regulation, or control regulated by the Commission on Health Economics Control (CHEK), except as they propose to provide equipment which costs exceed \$250,000.

Recommendations, Reference Committee 1:

Reference Committee No. 1 considered the Report of the Chairman, Board of Trustees, except the Report of the Ad Hoc Committee to Implement Resolution M (1991), and recommends amendment of the recommendation to adjust for inflation. The revised recommendation would then read as follows:

Private offices and clinics of physicians and other practitioners of the healing arts should be exempt from CON requirements, including but not limited to, licensure, supervision, regulation, or control regulated by the Commission on Health Economics Control (CHEK), except as they propose to provide equipment which costs exceed \$250,000 with adjustments for inflation.

Reference Committee No. 1 recommends adoption of Report No. 5 and its recommendation as amended.

Report of Kentucky Physicians Care Operating Committee

Although the Kentucky Physicians Care Operating Committee did not have a formal meeting this year, your Chairman and staff have been involved in some aspect of the program on a daily basis.

Since January 1, 1985, 114,541 individuals have been certified eligible for the Kentucky Physicians Care program and 45,715 referrals have been made, which we estimate resulted in over 205,700 physician encounters. This latter figure is estimated because, in most cases, once a patient is seen by a participating physician, he or she tends to continue seeing that physician and, as a result, does not continue to call the toll free number. New applications for certified eligible patients are received in the Headquarters Office every day.

The Headquarters Office continues to receive telephone inquiries and requests for referral, with a current average of 80 calls coming in on the toll free line daily.

The participation and support of the physicians in Kentucky continue to be excellent. Our current level of participating physicians is 2,372, representing a high percentage of the physicians who are actively practicing medicine in Kentucky. The Committee wishes to particularly recognize the continuing support of the primary care physicians who remain the initial contact point for the vast majority of referrals made through the program. The contribution made by these men and women is incalculable, and we are very appreciative of their efforts on behalf of the KPC patients and the medical profession in Kentucky.

The Kentucky Health Care Access Foundation continues as the primary funding source for the program. The Foundation underwrites the cost of the toll free telephone lines and two full-time employees. According to the Foundation, its financial contribution since the onset of the program through March 31, 1992, has been \$456,052.14.

Due to space limitations at KMA Headquarters, the KPC hotline

staff relocated their offices to the KMIC Headquarters Office which provides greater privacy for the hotline staff. KMIC is providing the KPC referral service space at no charge. Because of the close proximity of the KMA and KMIC Headquarters Offices, KMA continues to provide furniture, supplies, postage, computer equipment, and KMA staff involvement as needed. We are appreciative of KMIC's support of this project.

The Cabinet for Human Resources has continued to be extremely cooperative during the course of the project. Representatives from the Department for Social Insurance continue to work closely with KMA/KPC staff and provide a considerable amount of time and effort to the program, as have the 1,000 field workers in the 120 county CHR offices across the state.

Through the Kentucky Pharmacy Providers project, which began July 16, 1990, over 7,191 prescriptions have been filled at no charge to respective KPC patients. There are currently 397 pharmacies throughout the state participating in the program. We feel the support of the Kentucky Pharmacists Association and the many services provided by individual pharmacists add a much needed dimension to this program.

We especially wish to recognize the Pfizer/Roerig and G. D. Searle Companies for their continued generosity in making their full product lines available at no charge to KPC patients. The committee would particularly like to thank the leadership of these companies for their continuing support of the Kentucky Pharmacy Providers program and their extraordinary efforts and cooperation in working with KMA and the Foundation during the past two years.

Effective July 1, 1992, six members of the Johnson & Johnson family of companies began making available their entire line of prescription products to eligible KPC patients. Those companies are Iolab Corporation; Janssen Pharmaceutica, Inc; McNeil Consumer Products Company, McNeil Pharmaceutical; Ortho Biotech, Inc; and Ortho Pharmaceutical Corporation. Their products range from oral contraceptives to analgesics to allergy medications and antibacterials. The Committee is indeed grateful to the Johnson & Johnson leadership for their efforts and cooperation in making this participation possible.

Currently, all Kentucky acute care hospitals participate in KHA's Fair Share program, and 393 dentists have seen 810 referrals since the Kentucky Dental Care project began in 1991.

Kentucky, through the Kentucky Physicians Care program, continues to receive national recognition for this unique program, and Kentucky's medical profession is viewed by its peers as an active, progressive leader in dealing with the issue of indigent care.

The Committee believes that the Kentucky Physicians Care program has played a role in demonstrating the needs of the medically indigent in Kentucky and the fact that the voluntary private sector is working to address those needs.

The Committee feels there are advantages to the program being on a temporary, yearly renewal basis, and, therefore, suggests that KMA continue the Kentucky Physicians Care program through December 31, 1993, contingent on:

1. Program funding being continued, as appropriate, by the Kentucky Health Care Access Foundation, with KMA contributing in-kind services as done in 1985, 1986, 1987, 1988, 1989, 1990, 1991, and 1992;
2. A continuing commitment from the Cabinet for Human Resources to evaluate program applicants for eligibility, as its currently being done;
3. The Kentucky Hospital Association continuing its Fair Share program as currently operated;
4. The Kentucky Health Care Access Foundation continuing to vig-

ously encourage the active participation of all other health care delivery and/or financing organizations in Kentucky Physicians Care or the Fair Share program, as may be appropriate; and

5. The Kentucky Health Care Access Foundation making Kentucky legislators aware of the plight of those ineligible for Medicaid assistance solely because they do not meet the confusing and arbitrary requirements of the Medicaid program, while working to broaden the societal financial obligation necessary to provide care to those in need of such assistance.

As Chairman, I am most grateful to the many individuals and organizations that make this most significant program possible.

Russell L. Travis, MD
Chairman

RECOMMENDATIONS:

1. The Committee recommends that KMA continue the Kentucky Physicians Care program through December 31, 1993, contingent on:
 - A. Program funding being continued, as appropriate by the Kentucky Health Care Access Foundation, with KMA contributing in-kind services as done in 1985, 1986, 1987, 1988, 1989, 1990, 1991, and 1992;
 - B. A continuing commitment from the Cabinet for Human Resources to evaluate program applicants for eligibility, as is currently being done;
 - C. The Kentucky Hospital Association continuing its Fair Share program as currently operated;
 - D. The Kentucky Health Care Access Foundation continuing to vigorously encourage the active participation of all other health care delivery and/or financing organizations in Kentucky Physicians Care of the Fair Share program, as may be appropriate; and
 - E. The Kentucky Health Care Access Foundation making Kentucky legislators aware of the plight of those ineligible for Medicaid assistance solely because they do not meet the confusing and arbitrary requirements of the Medicaid program, while working to broaden the societal financial obligation necessary to provide care to those in need of such assistance.

Recommendations, Reference Committee 1:

Reference Committee No. 1 reviewed the Report of the Kentucky Physicians Care Operating Committee.

Reference Committee No. 1 recommends the adoption of the Report of the Kentucky Physicians Care Operating Committee.

RESOLUTION A

Funding of Health Care in Kentucky Fayette County Medical Society

WHEREAS, Governor Brereton C. Jones has appointed a Task Force on Health Care Access and Affordability and a Commission for Health Care Reform and requested they establish a plan to restructure Kentucky's health care financing and delivery system; and

WHEREAS, it is anticipated there will be a special session of the Kentucky General Assembly to legislate the restructuring of Kentucky's health care financing and delivery system; and

WHEREAS, the cost and provision of health care to all of Kentucky's citizens are concerns and responsibilities of society as a whole; and

WHEREAS, Kentucky physicians, as individuals, and KMA, through such programs as the Kentucky Physicians Care program, have long provided free care to large numbers of indigent patients; now therefore be it

RESOLVED, that KMA work strenuously in concert with other interested parties to achieve a funding plan for health care that is broad-based among Kentucky citizens and involves contribution from multiple segments of society according to their ability to pay; and be it further

RESOLVED, that KMA vigorously oppose any kind of funding plan that singles out physicians as a discrete element within society and places upon physicians a unique and disproportionate responsibility for the funding of health care for the citizens of Kentucky.

Recommendations, Reference Committee 1:

Reference Committee No. 1 heard testimony for Resolution A, Funding of Health Care in Kentucky, introduced by the Fayette County Medical Society.

Reference Committee No. 1 recommends the adoption of Resolution A.

RESOLUTION B

Health Care Reform Board of Trustees

WHEREAS, the following Resolution constitutes the policy of the KMA Board of Trustees as of April 1992; and

WHEREAS, it is the desire of the Board that this position be reaffirmed and adopted by the KMA House of Delegates; and

WHEREAS, Governor Brereton C. Jones has appointed a Task Force on Health Care Access and Affordability and a separate Commission for Health Care Reform; and

WHEREAS, the Governor has charged the Task Force and Commission with the responsibility of establishing a plan to restructure Kentucky's health care financing and delivery system; and

WHEREAS, ten physicians have been appointed to the Task Force, three specifically representing the Kentucky Medical Association; and

WHEREAS, many of KMA's long-standing legislative positions have not been reviewed and updated and may sharply restrict this Association's ability to arrive at necessary consensus with the various divergent interests which would be in the best long-term interest of patients and the profession; now therefore be it

RESOLVED, that the KMA House of Delegates reaffirms its policy regarding coordination of state legislative activities which include:

1. All state legislative proposals are to be coordinated by and channeled through the Committee on State Legislative Activities.
2. The composition, authority, and function of the Quick Action Committee are to be retained.
3. The composition, priority, manner, and time of introduction of state legislative proposals are to be left to the discretion of the Chairman of the Committee on State Legislative Activities and the Quick Action Committee.

and be it further

RESOLVED, that the House of Delegates, recognizing the enormous task KMA faces as dramatic transformations are proposed in the health care delivery system which will require immediate decisions, authorizes the Quick Action Committee, in consultation with the Executive Committee when indicated, to set legislative policies determined to be in the best interest of the Association, and to represent the Association in all matters relating to the special Task Force, Commission, and Special Session; and be it further

RESOLVED, that the President of KMA is authorized to call emergency meetings of the KMA Board of Trustees as necessary, and special sessions of the House of Delegates in accordance with the Constitution and Bylaws if appropriate; and be it further

RESOLVED, that the Chairman of the KMA Committee on State Legislative Activities shall keep the membership of KMA, the House of Delegates, and the Board of Trustees fully informed as to the progress of the Task Force and Commission deliberations and provide membership details of KMA's plans and recommendations on becoming involved.

Recommendations, Reference Committee 1:

Reference Committee No. 1 next heard testimony for Resolution B, Health Care Reform, introduced by the Board of Trustees.

Reference Committee No. 1 recommends the adoption of Resolution B.

RESOLUTION C

The Role of Organized Medicine in Health Care Policy Board of Trustees

WHEREAS, the American Medical Association House of Delegates has voted for the AMA to seek appropriate legislative, regulatory, and judicial action providing for formal physician organization involvement in all areas of public and private sector health care policy development and implementation in order to maintain the role of physician as patient advocates. This formal physician involvement shall include, but not be limited to, the following areas of health care policy: review of quality and appropriateness of care, appropriateness of payments and fees, negotiation of reimbursement, and predictability of health care costs, and shall not exclude any other areas of legislative or regulatory activities affecting physicians; now therefore be it

RESOLVED, that the KMA fully support the AMA's efforts to accomplish these goals, and to supplement those efforts as appropriate; be it further

RESOLVED, that the KMA also support the AMA's efforts to continue to seek the necessary changes in the antitrust laws to permit involvement of organized medicine in the negotiating process, which is inherent in the development and implementation of all areas of health policy; and be it further

RESOLVED, that the KMA, through its officers and Board of Trustees, shall serve as the formal physicians' organization, to the extent law allows, in all negotiations associated with development and implementation of health care reform that shall be considered by the 1992 Special Session of the Kentucky State Legislature called by Governor Brereton Jones; and be it further

RESOLVED, that the KMA Board of Trustees explore and define the options and activities necessary to achieve the policies set forth by the establishment of formal physician involvement in the development and implementation of health care policy and to include options outlining alternative approaches and innovative concepts (such as mandatory membership in the state and/or national medical societies) that may be necessary to allow the voice of medicine to speak with maximum authority.

Recommendations, Reference Committee 1:

The Committee heard testimony regarding Resolution C, The Role of Organized Medicine, introduced by the Board of Trustees. The Committee recommends the last "Resolved" be amended by deletion. The "Resolved" would then read as follows:

RESOLVED, that the Board of Trustees explore and define the options and activities necessary to achieve the policies set

forth by the establishment of formal physician involvement in the development and implementation of health care policy and to include options outlining alternative approaches and innovative concepts (such as mandatory membership in the state and/or national medical societies) that may be necessary to allow the voice of medicine to speak with maximum authority.

Resolution C, adopted as amended, reads as follows:

WHEREAS, the American Medical Association House of Delegates has voted for the AMA to seek appropriate legislative, regulatory, and judicial action providing for formal physician organization involvement in all areas of public and private sector health care policy development and implementation in order to maintain the role of physician as patient advocates. This formal physician involvement shall include, but not be limited to, the following areas of health care policy: review of quality and appropriateness of care, appropriateness of payments and fees, negotiation of reimbursement, and predictability of health care costs, and shall not exclude any other areas of legislative or regulatory activities affecting physicians; now therefore be it

RESOLVED, that the KMA fully support the AMA's efforts to accomplish these goals, and to supplement those efforts as appropriate; be it further

RESOLVED, that the KMA also support the AMA's efforts to continue to seek the necessary changes in the antitrust laws to permit involvement of organized medicine in the negotiating process, which is inherent in the development and implementation of all areas of health policy; and be it further

RESOLVED, that the KMA, through its officers and Board of Trustees, shall serve as the formal physicians' organization, to the extent law allows, in all negotiations associated with development and implementation of health care reform that shall be considered by the 1992 Special Session of the Kentucky State Legislature called by Governor Brereton Jones; and be it further

RESOLVED, that the KMA Board of Trustees explore and define the options and activities necessary to achieve the policies set forth by the establishment of formal physician involvement in the development and implementation of health care policy and to include options outlining alternative approaches and innovative concepts that may be necessary to allow the voice of medicine to speak with maximum authority.

RESOLUTION U

Change of Rules of Order Board of Trustees

WHEREAS, Chapter XI of the Bylaws of this Association provide that all deliberations will be governed by the *Sturgis Standard Code of Parliamentary Procedure*; and

WHEREAS, a new volume of Rules of Order authored by James E. Davis, MD, former speaker of the House of Delegates of the American Medical Association, is a current and more appropriate text for conduct of meetings; now therefore be it

RESOLVED, that this House of Delegates adopt the current edition of Davis' *Rules of Order* as the parliamentary guide for all deliberations; to become effective at the end of this session; and be it further

RESOLVED, that the KMA Bylaws be appropriately amended to reflect this action.

Recommendations, Reference Committee 1:

Reference Committee No. 1 next considered Resolution U, Change

of Rules of Order. The Committee recommends Resolution U be adopted.

Mr Speaker, Reference Committee No. 1 recommends the adoption of this report as a whole.

Mr Speaker, I want to thank the members of Reference Committee No. 1 who worked hard to assist the House of Delegates on these matters. Members of the Committee were: John V. Borders, MD, Lexington; John D. Noonan, MD, Paducah; H. Michael Oghia, MD, Russell Springs; and Scott B. Scutchfield, MD, Danville. I would also wish to thank Theresa Wilson for her help and guidance in preparation of this report.

Respectfully submitted,
REFERENCE COMMITTEE NO. 1

Howard B. McWhorter, MD, Ashland, Chairman
John V. Borders, MD, Lexington
John D. Noonan, MD, Paducah
H. Michael Oghia, MD, Russell Springs
Scott B. Scutchfield, MD, Danville

Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE NO. 2

Samuel G. Eubanks, Jr, MD, Louisville, Chairman

13. Report of the Scientific Program Committee
14. Report of the Scientific Exhibits Committee
15. Report of the Continuing Medical Education Committee
16. Report of the Council for Continuing Medical Education
17. Report of the Cancer Committee
18. Report of the Physician Manpower Committee
19. Report of the Hospital Medical Staff Section
- Resolution D — Deleterious Effects of Tobacco Use (Board of Trustees)
- Resolution E — Primary Care Preceptorships (Board of Trustees)
- Resolution I — Hospital Medical Staff Bylaws (C. Dale Brown, MD, Paducah)
- Resolution J — Mandatory Continuing Medical Education (Board of Trustees)
- Resolution K — Survey of Physicians Who Leave Kentucky (KMA Resident Physicians Section)
- Resolution T — Increasing the Number of Primary Care Physicians (Board of Trustees)

ITEMS FOR CONSENT

Reference Committee No. 2 reviewed the following items and recommends they be filed, as indicated, by consent of the House, without discussion:

13. Report of the Scientific Program Committee — filed
14. Report of the Scientific Exhibits Committee — filed
15. Report of the Continuing Medical Education Committee — filed
16. Report of the Council for Continuing Medical Education — filed
18. Report of the Physician Manpower Committee — filed
19. Report of the Hospital Medical Staff Section — filed

Mr Speaker, Reference Committee No. 2 recommends adoption of the Consent Calendar as a whole.

Report of the Scientific Program Committee

“Medical Challenges in an Age of Risk” was selected by the Scientific Program Committee as the overall theme for the 1992 KMA Annual Meeting Scientific Program. Each morning session will focus on the theme from the perspective of the various specialties participating in the Meeting. The Committee members and representatives from the 23 specialty societies have worked hard to bring some of this country’s outstanding speakers to the Meeting, and it is hoped that the membership will find their presentations useful.

The Scientific Program was planned last fall and a meeting was held in December with the presidents and/or representatives of the 23 specialty groups that will participate in the annual session. Afternoon specialty groups’ scientific programs held in conjunction with the morning general sessions have proven invaluable, and provide an excellent contribution to the continuing medical education of the membership. I personally appreciate the excellent cooperation the Committee has had from the specialty societies in planning the overall Meeting, and I thank them for their suggestions and assistance.

The 1991 Annual Meeting was held at the Hyatt Regency Hotel/Lexington Center, and although attendance was lower than it had been in the last couple of years, it was higher than at our last trip to Lexington in 1988.

Exhibitors were asked to fill out evaluation forms on Tuesday, Wednesday, and Thursday during the 1991 Meeting rather than on Thursday only, as in the past. This allowed a better assessment of exhibitors’ viewpoints which were, overall, positive.

Results from physicians’ evaluation forms were very positive and revealed that physicians attended the 1991 Annual Meeting program because of the program content.

The Kentucky Medical Group Management Association (KMGMA) met in conjunction with the 1991 Annual Meeting, and the Kentucky Medical Insurance Company also sponsored a Risk Management workshop for office assistants during the ’91 Meeting. Both of these functions helped with our registration figures and brought more people into the Exhibit Hall.

The 1992 KMA Annual Meeting will be held at the Hyatt Regency Hotel/Commonwealth Convention Center in Louisville. Meetings of the KMA Board of Trustees, House of Delegates, Reference Committees, KEMPAC, and Auxiliary, as well as various food functions will be held in the Hyatt Regency Hotel. General registration, specialty groups meetings, general sessions, and the technical exhibit hall will be located in the Commonwealth Convention Center. We urge members and their staffs to visit the exhibits. These informal contacts offer opportunities to discuss new products and familiarization with new equipment, free from the interruptions or distractions of the office or hospital.

The scientific sessions are again accredited for AMA Category 1 continuing medical education credit and are also approved for CME credit by the American Academy of Family Physicians.

I am very grateful for the efforts of those who have assisted in the formation of the program, particularly the Program Committee, specialty group presidents, and program chairmen. Suggestions for future programs are always welcomed by the Scientific Program Committee.

Sonia R. Teller, MD, PhD
Chairman

Report of the Scientific Exhibits Committee

The Scientific Exhibits Committee does not meet formally. Its activi-

ties are carried out by mail and telephone. We notify members through the *Journal* of the KMA and the "Communicator" of the availability of space and provide applications to interested individuals. In 1991 we had eight scientific exhibits approved by the Scientific Exhibits Committee. We also provide exhibit space for organizations such as the Impaired Physicians Committee and the Cabinet for Human Resources. We wish to express our appreciation to the following exhibitors at the 1991 Annual Meeting:

Carotid Endarterectomy: Current Concepts and Controversies

Sibu P. Saha, MD; Anthony G. Rogers, MD; and Gary F. Earle, MD

Cumulative Trauma Disorders

Morton L. Kasdan, MD; John Stutts

Management of Fractures of the Hand

Morton L. Kasdan, MD; Jan Chipman, MD; John Stutts

Diabetes 2000

Kentucky Academy of Eye Physicians & Surgeons

Diabetes Retinopathy — Diagnosis and Management

Charles F. Mahl, MD; Steven M. Bloom, MD

How to Formulate A Differential Diagnosis of TMJ

John D. Tarrant, DMD

Kentucky BEST START Program

Kentucky Cancer Program

Congratulations to the exhibitors of "Management of Fractures of the Hand," recipient of the 1991 Award for Excellence.

I want to take this opportunity to thank the members of the Committee for serving. The scientific exhibits area adds tremendously to the overall success of the Annual Meeting and remains an integral part of the activities and the dissemination of information and science. The Committee continues to urge physicians to visit the scientific exhibits area.

Richard A. Kielar, MD
Chairman

Report of the Continuing Medical Education Committee

The Continuing Medical Education Committee has enjoyed an extremely busy year, formally meeting three times and holding a seminar for Committee members and Directors of Continuing Medical Education of accredited facilities.

One major effort of the Committee has been resurveys of four institutions previously accredited by the Committee. The Committee serves as the accreditation arm of KMA's CME efforts. In this role, the Committee surveys, accredits, and monitors hospitals and other facilities which then conduct their own singular CME programs.

Survey teams were appointed for four institutions which had reapplied for accreditation. One institution was granted an extension on its resurvey until 1993 in order to improve upon deficiencies that were discovered prior to its resurvey date. Each survey team consists of two members of either the CME Committee or Council and KMA staff. Once the team is appointed, individual institutions are contacted to determine mutually convenient dates when local CME programs are being offered.

The survey team first reviews the application; then conducts a survey to review the application's contents; and finally formulates accrediting recommendations through a survey report, which is then voted on by the whole Committee. During the year, one new application was submitted and a survey of this institution will be accomplished at a date after the Annual Meeting.

Interim reports from two institutions were considered by the

Committee. A portion of the accreditation process requires that accrediting facilities submit interim reports between surveys as a method of monitoring their activities. Both institutions had been granted provisional accreditation for one year, to be resurveyed after that year expires. Their interim reports cover the activities for the first six months of their provisional accreditation.

The Committee continued its annual solicitation for nominees for the Educational Achievement Award. Nominations were received and candidates will be considered by the Committee. The Committee decided that the selection process and requirements to be nominated for the award were insufficient and formed a Subcommittee to strengthen the selection process and publicity for soliciting nominees for the award.

The Subcommittee felt that the nominations submitted were not detailed enough for the CME Committee to select the most qualified applicant. The Subcommittee discussed a point system with categories of teaching, research, clinical application in medical practice patient education, and community involvement. It was decided that assigning value to each category and selecting the winner on the most points is the fairest way to select a nominee. The Subcommittee also suggested soliciting nominees from the KMA CME Council and Committee, as well as the Board of Trustees. Previously, nominees were solicited only from specialty group presidents, chiefs of staffs, deans of the University of Louisville School of Medicine and University of Kentucky College of Medicine, and county society secretaries.

The Committee noted new developments relating to the CME accreditation process this year that were generated at the national level. First, the Accreditation Council for Continuing Medical Education (ACCME) requested that the Committee seek committee members with a broader geographic representation. Recommendations from the Committee included inviting Directors of Medical Education from accredited facilities and Area Health Education Center (AHEC) Directors from around the state. Since Committee members must be physicians, these new appointees would serve as ex-officio representatives.

The national accrediting body, ACCME, noted that the Federal Drug Administration (FDA) may attempt to oversee continuing medical education. The FDA proposed a concept draft paper on industry sponsorship of continuing medical education. This document threatens government regulation of medical meetings. The specter of government involvement is making CME professionals take a closer look at the entire process before the federal regulators do. In return, the ACCME has committed to review CME programs more stringently with regards to compliance of Essentials and Guidelines. The ACCME has published revisions to guidelines on commercial support for accredited CME, which have been strengthened to enforceable standards, effective May 4, 1992. (Standards are equal in force to the Essentials, and CME sponsors that do not comply with them are subject to probation or even withdrawal of their accreditation. Guidelines are just strong suggestions, without the force of sanctions.) This new push by the FDA and ACCME will mean increased activity for the KMA CME Committee. In addition, the ACCME requested experienced site surveyors for national institutions from our Committee, as a result of increased activity from the FDA requirements.

Another major initiative of the CME Committee was the issue of mandatory continuing medical education requirements for Kentucky physicians. The Committee recommended that KMA seek mandatory CME to be implemented by the Kentucky Board of Medical Licensure by regulation.

The CME Committee recommended that physicians receive

150 hours of CME over a three-year period, of which 60 hours must be Category 1 credit. The Committee emphasized to the Board that it was opposed to specific CME subjects. Mandating a certain number of hours provides flexibility for a variety of learning opportunities for Kentucky physicians. Passage of mandatory CME by the House of Delegates and the development of regulations through the Medical Licensure Board will have a profound effect on the workload of the CME Committee. More institutions in the state will pursue accreditation, increasing site surveys, resurveys, etc.

The Committee undertook this year to enhance its needs assessment capabilities in order to better serve continuing medical education in Kentucky. A statewide needs assessment survey was conducted cooperatively by the Committee; the CME departments of the University of Louisville and the University of Kentucky; the two Area Health Education Centers; and the Board of Medical Licensure, with financial support by the Upjohn Company. The survey was responded to by 53% of Kentucky physicians. The survey form consisted of nine sections, which addressed demographic information, CME program factors, the Physicians Recognition Award, AMA's Ethical Guidelines, topics for CME, program location, and preferences for programs on certain days of the week.

The statewide survey provided the Committee with valuable information. With such a high response rate, the survey can be distributed to local accredited facilities, which will allow them to determine the needs for physician education programs. Determining needs from this survey and providing programs from the determined needs will allow local accredited facilities to meet proper ACCME Essentials and Guidelines.

The CME Committee and Council held a joint seminar for all CME Committee Chairmen and Directors of Medical Education at institutions from across the state. This was a highly successful seminar, with attendance by 40 people who deal with continuing medical education. Topics covered included, "How to Prepare for a Site Visit"; "The Essentials of a Continuing Medical Education Program"; "Guidelines for Commercial Support"; "PRA Update and the Accreditation Process"; and a panel discussion on "Outreach and Off-Site Programs and Other Conundrums."

The Committee has an additional meeting scheduled for October and anticipates extremely increased activity in 1992-93.

We would like to thank the KMA Board of Trustees for being permitted to serve the Association.

Larry P. Griffin, MD
Chairman

Report of the Council on Continuing Medical Education

The Council on Continuing Medical Education acts as the provider of CME for the Association. The main educational opportunity offered is the Annual Scientific Program. In January, the Council met jointly with the CME Committee. The purpose of the joint meeting was to refamiliarize all members with the Essentials of CME which describe the process and organization of all CME efforts as directed by the Accreditation Council on Continuing Medical Education (ACCME). This document is the basis of all sponsored CME programs throughout the country. Although it is revised periodically, its basics remain the same, but refamiliarization was felt to be appropriate as well as helpful to new Council members.

Following the joint meeting, a separate meeting was held to discuss specific Council items. Of most significance, it was noted that the KMA's provider status was subject for resurvey by the

ACCME. The survey was scheduled for June 7 in Chicago and would constitute a reverse site survey.

In preparation for the reverse site survey, results of the previous survey were considered and actions to resolve discrepancies were noted. This information, together with a description of other efforts the Council had taken to refine the provider process, were included, and staff met with a three-member team of the ACCME in Chicago to defend the application. It was noted that additional work on developing and stating CME objectives for each course was appropriate, that CME needs assessment should be related more closely to the development of goals, and that better coordination between the Council and the Annual Meeting Scientific Program Committee was necessary. On balance, the reverse survey was beneficial and informative to the Chairman and staff, as well as to the ACCME team members. Subsequent to the survey, the Council was notified in the early part of July that continuing accreditation had been approved for a period of four years.

As a provider, the Council is authorized to jointly sponsor CME efforts with nonaccredited organizations, but the Council adopted the tacit position that joint sponsorship activities would generally be avoided. It was felt that the purpose of the overall CME program was for local groups and institutions to become self-accrediting.

During the coming year, the Council hopes to refine its activities in keeping with comments provided by the ACCME on the survey application. Some of these activities will include closer input into the development of the Annual Scientific Program, working more closely with specialty groups on needs assessment, evaluating the activities of CME programs, and consideration of joint sponsorship activities.

W. David Hager, MD
Chairman

Report of the Physician Manpower Committee

The focus of the efforts of the Physician Manpower Committee this year continued to be directed toward physician maldistribution. With an excess of physicians in different areas of the United States, Kentucky's difficulty will continue to be a problem of maldistribution. Kentucky is currently the sixth most underserved state by rural physicians.

Current literature continues to indicate that the most important issues affecting rural shortages are lower reimbursement rates; liability premiums; professional isolation; lack of support equipment and staff; insufficient population and economic base; lack of cultural life; poor educational opportunities for children; spouse dissatisfaction and lack of job opportunities for spouses; heavy workload and lack of relief for cross coverage; and severe financial problems of rural hospitals.

In approaching and analyzing the problems of maldistribution and attracting physicians to rural areas, the Committee was fortunate to have input and assistance from the admission staffs of both medical schools, the Area Health Education Centers, and the Department for Health Services (Cabinet for Human Resources). All of these organizations, together with KMA, have similar interests in this area.

Both the University of Louisville and University of Kentucky medical schools' recruitment efforts include holding recruitment meetings at colleges and universities and speaking to students about their pre-med programs, attending college preview nights throughout the state, and participating in the SMART (Science, Mathematics, and Rising Talents) program encouraging inner-city black stu-

dents to develop an interest in the sciences.

The medical schools announced the number of applicants is on the upturn. In the late 1980s, many physicians were discouraging college graduates from going to medical schools because there was thought to be a glut of physicians. It is estimated that this influenced over 30% of admissible students to turn to other professions' graduate programs.

With a growing pool of applicants, admission requirements have become more stringent, with a GPA of 3.4, a science GPA of 3.6, and an MCAT of 50th percentile in four categories being required for consideration.

Beginning with the spring semester of the 1991-92 school year the Committee has arranged for medical students and/or medical residents to visit rural and inner-city high schools they attended, accompanied by an area physician, to provide information and relate personal experiences to high school students. Over 100 medical students have volunteered their time to participate in this effort.

This recruitment activity, it is felt, will be most productively directed toward freshmen and sophomore high school students. An area of focus will be informing students of grants and scholarships available from a variety of sources which may be generally unknown to aspiring medical school applicants. Other positive aspects of the medical profession will be addressed at the visits to encourage the high school students to look at medicine as a career. Other efforts of like nature will be undertaken by the organizations already mentioned.

The Committee discussed the new RBRVS payment system and its effect on encouraging physicians to locate in rural areas in hopes of higher reimbursement levels. Unfortunately, RBRVS has not made a major positive impact and cannot be considered a recruitment tool.

The Rural Kentucky Medical Scholarship Fund announced a very positive initiative that will help fund physician start-up costs to those who choose to relocate in rural and critical need areas.

It is the feeling of the Committee that resolution of the distribution problems will take the concerted efforts of the medical schools, the Cabinet for Human Resources, Area Health Education Centers, and KMA. It is the Committee's intent to further pursue these activities from both the perspective of practical efforts such as the high school visits, and from a standpoint of increased incentives for primary care physicians to establish practice in rural areas.

Robert R. Goodin, MD
Chairman

Report of the Hospital Medical Staff Section

The Hospital Medical Staff Section (HMSS) was established in 1984 to provide a forum for discussion of mutual problems of hospital medical staffs, and continues to see increased participation by hospital medical staff representatives in activities of the Section. The Steering Committee met in May to plan this year's Section meeting for August 26. The Steering Committee works toward planning educational programs each year that will include information for physicians that is vital to their individual practices and their function as members of the medical staff of their hospitals.

We would like to thank John O'Brien, MD, for his help in obtaining the assistance of Methodist Evangelical Hospital, Louisville, which has graciously agreed to provide the location of the HMSS Annual Meeting and assist in providing meals and refreshments during that session. As in years past, an excellent program has been planned for the 1992 HMSS Annual Meeting which will

include information on credentialing problems faced by medical staffs in dealing with both physicians and nonphysician providers; written guidelines on drafting of medical staff bylaws will be provided and discussed; and State Senator David Karem, (D), Louisville, member of the Commission on Health Care Reform, and Russell Travis, MD, Lexington, KMA Board Chairman and member of the Health Care Task Force, will discuss the latest information on health care reform and the proposed special session of the Kentucky Legislature planned for November 1992.

During the business portion of the HMSS Annual Meeting the positions of Chairman and Vice Chairman of the Steering Committee are to be filled by election. Nominations will be accepted from the Nominating Committee as well as from the floor, and both positions are for three-year terms.

The HMSS would like to thank Steve S. Kraman, MD, Lexington, Chairman, and the other members of the 1991-92 HMSS Nominating Committee, for their dedicated work in selecting candidates for these positions. Other members of the Nominating Committee were Chris McCoy, MD, Owensboro; William Mitchell, MD, Richmond; William Pratt, MD, London; and Alfred Thompson, Jr, MD, Louisville.

Names being proposed by the Steering Committee for election by the Section as the 1992-93 HMSS Nominating Committee are William Pratt, MD, London, Chairman; William Albert, MD, Russellville; Chris McCoy, MD, Owensboro; Madonna Ringswald, DO, LaGrange; and John O'Brien, MD, Louisville.

Several KMA-HMSS members attended the Annual Meeting of the AMA Hospital Medical Staff Section and the AMA Annual Meeting in Chicago in June of this year. The AMA-HMSS considered 54 Resolutions and 24 HMSS Governing Council Reports. Fifteen Resolutions were forwarded to the AMA House of Delegates for consideration at the 1992 Annual Meeting. The House of Delegates adopted 10 HMSS Resolutions or similar Resolutions in lieu of an HMSS Resolution; adopted a Board of Trustees Report in lieu of one Resolution; and referred four Resolutions to the Board of Trustees. The following were among the large number of issues debated by the HMSS in Chicago:

Oppose the Patients' Bill of Rights as currently proposed by the American Hospital Association with particular emphasis on the proposal to eliminate all references to physicians and the utilization of the term "care givers" as those individuals responsible for care of those patients, and the possibility that the Patients' Bill of Rights be developed as a joint document between the AMA and the AHA, to establish a dialog with the AHA in an attempt to develop a joint strategy to solve the health care crisis in this country.

Seek enactment of federal legislation and/or change in HCFA policy to establish more equitable standards for fair and prompt payment for both primary care and specialists' positions.

Seek uniformity among Medicare carriers and other third-party payors in application of concurrent care policies.

Request that HCFA appropriately reimburse primary care physicians for medically necessary documented services such as counseling and coordination of care in the surgical patient.

Communicate to HCFA the importance of understanding that more than one physician can be involved in a case and that the carrier or insurance company not expect a physician to manage a medical problem outside his/her area of expertise or specialty, and that both the primary care physician or other specialist be reimbursed for this care in accordance with their

responsibilities.

Use all appropriate means to have HCFA and/or its carriers not routinely deny all but the first claim received for services rendered to the same patient on the same day for the same diagnosis.

Have the AMA provide comment to the IRS that direct billing by physicians for services to patients is not covered by revenue procedures 82-14 and 82-15 and should be explicitly covered by a revised procedure.

Seek appropriate legislative, regulatory, and judicial action providing for formal physician organization involvement in all areas of public and private sector health care policy development and implementation including, but not limited to, review of quality and appropriateness of care; appropriateness of payments and fees; negotiation of reimbursement; and predictability of health care costs.

Seek model legislation for due process in the managed care environment including meaningful due process protections; appropriate organization of the medical staff for the provision of quality assurance, credentialing, and peer review; and annual audits to assure that incentive withholds for the payment of services are reimbursed in a timely fashion.

Urge adoption of a policy that all hospitals should include medical staffs in any review of proposed new or renewed managed care contracts, particularly as they relate to provisions for appropriate credentialing, due process, and medical review.

As Chairman of the KMA Hospital Medical Staff Section, I would like to take this opportunity to express appreciation to the medical staffs and Section representatives of those hospitals who have chosen to participate in the KMA-HMSS. I am also grateful for the dedication of the members of the 1991-92 Steering Committee for their efforts to make the HMSS an effective KMA activity. Those members are Earl P. Oliver, MD, Scottsville, Vice Chairman; Rex Cox, MD, Louisville, Secretary; William Pratt, MD, London, Delegate; John D. O'Brien, MD, Louisville, Alternate Delegate; and Members at Large Robert J. Emslie, MD, Bowling Green, and William O'Bryan, MD.

We will continue working toward our goal of having active participation from the hospital medical staff of each eligible hospital in Kentucky. This is a positive step towards assuring good working relationships between physicians and hospitals. I urge each physician to see that the medical staff of his or her hospital becomes actively involved in the HMSS and all KMA activities.

Donald J. Swikert, MD
Chairman

END OF CONSENT CALENDAR ITEMS

Report of the Cancer Committee

The Cancer Committee met on one occasion this year to review various activities in the field of cancer treatment and research.

The Cabinet for Human Resources (CHR) program to increase screening for breast and cervical cancer for low-income women was discussed.

In 1990, the Kentucky General Assembly passed HB 62 mandating coverage for mammography under all health insurance policies and establishing a sliding scale for the number of mammography

screenings available to various age groups. The legislation limits coverage to \$50 per mammogram. The 1990 Legislature also established a breast cancer screening program and fund.

Gilbert Friedell, MD, Director, University of Kentucky Markey Cancer Center, brought concerns to the Committee that the information about the program was not reaching enough indigent women, and that these women were not receiving the tests they needed. Doctor Friedell explained that if more women were screened for breast cancer, the overall cost of each screening would decrease, making it more affordable for all women.

Depending on the area of the state, the number of women receiving mammograms, and the quality of the screening, the cost to each woman for a mammogram varies. Members of the Committee agreed that a misconception exists as to what is included in a mammogram. There appear to be considerable differences in terms of what services, if any, are included in a "screening" mammogram. The program calls for two views and does not include breast examinations.

Doctor Friedell reminded the Committee that the goal of the program is to educate indigent women of Kentucky about breast cancer, and the availability of mammograms at inexpensive rates. The Committee agreed that KMA should make an effort to include in its publications the necessity of breast cancer education. The Committee has placed an article in the "Communicator" about the mammography screenings program through CHR in Kentucky to urge radiologists to contract with local health departments to provide indigent women a mammography screening. The KMA is working with CHR, specialty groups, the American Cancer society, and others to assist the Department for Health Services, Chronic Disease Branch, in reaching indigent women in order that they may be screened.

In addition, the KMA Cancer Committee submitted a plan to the Cervical Cancer Work Group of the Department for Health Services, Chronic Disease Branch, which has set a goal to significantly lower the death rate of indigent women from cervical cancer over the next decade. The Committee has agreed to work with the Cervical Cancer Work Group to develop a questionnaire for a possible survey of physicians on recognizing and treating cervical cancer. The Committee will continue to work with all groups committed to reducing cancer in Kentucky.

The Committee published the results of the 1990 smoking survey in the KMA "Communicator" in order to inform the membership of the Kentucky Medical Association. The results indicated that Kentucky physicians were overwhelmingly in opposition to the use of tobacco products.

As recommended by Reference Committee No. 2 at the 1991 Annual Meeting, the Committee contacted CHR to recommend that it consider using a video tape entitled, "Breast Cancer Treatment Options: Choosing What is Right For You" for distribution to patients and physicians in order to inform a larger audience on treating breast cancer.

The Committee looks forward to expanded activity in 1992-93. We thank the KMA Board of Trustees for being permitted to serve, and urge members to refer relevant concerns to the Committee.

Clinton C. Cook, III, MD
Chairman

RECOMMENDATIONS:

1. The Cancer Committee recommends that there be a mammography screening program for indigent women, directing resources

to an even distribution of contracts at local facilities throughout the state.

2. The Cancer Committee recommends that it be made known that a subsidy is available through the breast screening fund established in SB 41 by the 1990 General Assembly.
3. The Cancer Committee recommends consulting with certain heavy-volume providers in order to determine their level of costs and expenses for screening mammograms and to encourage them to inform the KMA Cancer Committee on their findings.
4. The Cancer Committee recommends getting a list of current contracts from the Department for Health Services of counties that are currently providing mammograms, also indicating which providers are accredited by the American College of Radiology.

Recommendations, Reference Committee 2:

Reference Committee No. 2 reviewed the Report of the Cancer Committee and recommends the Report be filed and its Recommendations be adopted.

The Reference Committee expresses its appreciation for the work of all these committees.

RESOLUTION D

Deleterious Effects of Tobacco Use Board of Trustees

WHEREAS, Kentucky leads the nation in both prevalence of cigarette smoking and smoking-attributable mortality, according to the Centers for Disease Control; and

WHEREAS, cigarette smoking is the greatest single cause of preventable death in the United States, according to the Surgeon General; and

WHEREAS, smoking is directly related to 500,000 deaths per year in the United States from cancer, heart disease, and emphysema; and

WHEREAS, smoking-related cancers constitute one-third of all cancers, causing more than 150,000 deaths per year; and

WHEREAS, the Kentucky Medical Association has endorsed the concept of eliminating access to tobacco by children; and

WHEREAS, the Kentucky Medical Association has opposed the use of tobacco on school property; and

WHEREAS, the Kentucky General Assembly is encouraged to increase cigarette taxes in order to discourage teenage smoking; now therefore be it

RESOLVED, that the Kentucky Medical Association encourage physicians to intensify educational efforts directed to patients on the deleterious effects of tobacco use; and be it further

RESOLVED, that the Kentucky Medical Association encourage the Kentucky General Assembly to increase its attention to the serious health problem of tobacco product use and the trend of teenage smoking.

Recommendations, Reference Committee 2:

Reference Committee No. 2 considered Resolution D, Deleterious Effects of Tobacco Use, introduced by the Board of Trustees.

Reference Committee No. 2 recommends that Resolution D be adopted.

RESOLUTION E

Primary Care Preceptorships Board of Trustees

WHEREAS, Kentucky suffers from an inadequate number and distribution of primary care physicians; and

WHEREAS, choice of specialty by students is affected by sev-

eral factors, which include exposure to difference practice modes during the formative medical school years; and

WHEREAS, evidence exists to show that practice location is affected by residence of origin, as well as training site; now therefore be it

RESOLVED, that KMA work with the Kentucky Academy of Family Physicians, the Kentucky Chapter of the American College of Physicians, the Kentucky Chapter of the American College of Obstetrics and Gynecology, the medical schools, and individual members to coordinate preceptorships for medical students in private practice primary care settings; and be it further

RESOLVED, that such training episodes occur by the third year of medical school study.

Recommendations, Reference Committee 2:

Reference Committee No. 2 next considered Resolution E, Primary Care Preceptorships, introduced by the Board of Trustees.

The Committee felt that Resolution E should be amended by inserting "the Kentucky Society of Internal Medicine and the Kentucky Pediatric Society" after "the Kentucky Academy of Family Physicians" in the first "Resolved," and also by amending the last "Resolved" by inserting "prior to" in lieu of "by." The "Resolveds" of Resolution E, with deletion and addition, would then read as follows:

RESOLVED, that KMA work with the Kentucky Academy of Family Physicians, the Kentucky Society of Internal Medicine, the Kentucky Pediatric Society, the Kentucky Chapter of the American College of Physicians, the Kentucky Chapter of the American College of Obstetrics and Gynecology, the medical schools, and individual members to coordinate preceptorships for medical students in private practice primary care settings; and be it further

RESOLVED, that such training episodes occur ~~by~~ prior to the third year of medical school study.

Reference Committee No. 2 recommends adoption of Resolution E, as amended.

Russell L. Travis, MD, Chairman of the Board of Trustees, was recognized, who made a motion, on behalf of the Board, that the word "occur" in the final Resolved be changed to "begin," so that the sentence would read, "Resolved, that such training episodes begin prior to the third year of medical school study." The motion was seconded and carried.

Resolution E, adopted as amended by the Reference Committee and House of Delegates, reads as follows:

WHEREAS, Kentucky suffers from an inadequate number and distribution of primary care physicians; and

WHEREAS, choice of specialty by students is affected by several factors, which include exposure to difference practice modes during the formative medical school years; and

WHEREAS, evidence exists to show that practice location is affected by residence of origin, as well as training site; now therefore be it

RESOLVED, that KMA work with the Kentucky Academy of Family Physicians, the Kentucky Society of Internal Medicine, the Kentucky Pediatric Society, the Kentucky Chapter of the American College of Physicians, the Kentucky Chapter of the American College of Obstetrics and Gynecology, the medical schools, and individual members to coordinate preceptorships for medical students in private practice primary care settings; and be it further

RESOLVED, that such training episodes begin prior to the third year of medical school study.

RESOLUTION I**Hospital Medical Staff Bylaws****C. Dale Brown, MD, Paducah**

WHEREAS, with health care reform on the horizon and a dedication and determination by state and federal politicians to prohibit physicians from playing a role in the reform process, it behooves the physicians of this great Commonwealth to strengthen their health care positions at the local levels; and

WHEREAS, there exists an ever-increasing trend over the last few years for hospitals to become excessively active in weakening hospital medical staff bylaws, under the guise of the 1986 Quality Act and new JCAHO regulations; and

WHEREAS, changes in medical staff bylaws suggested by hospitals and their "paid-for" consultants are "*absolutely*" necessary to the hospital in order to receive JCAHO approval, and hospitals are willing to pay tens of thousands of dollars to "their" legal firms and "their" consultants in order to get these changes; and

WHEREAS, an intense effort now exists on the part of hospitals to legally reduce and even eliminate through the courts the rights of an individual medical staff member to obtain a fair hearing and due process; now therefore be it

RESOLVED, that the Kentucky Medical Association sponsor appropriate Resolutions to the House of Delegates of the American Medical Association (AMA) that would address the hospital's position to make changes in hospital medical staff bylaws which reduce or eliminate due process and fair hearing rights; and be it further

RESOLVED, that the KMA work with the AMA to alert hospital and medical staffs of this ongoing ground roots concern and to make available *model* medical staff bylaws and a list of appropriate legal counsels, to represent hospital medical staffs.

Recommendations, Reference Committee 2:

Reference Committee No. 2 next considered Resolution I, Hospital Medical Staff Bylaws, introduced by C. Dale Brown, MD, Paducah. Reference Committee No. 2 would like to note that at the request of the 1991 House of Delegates, guidelines (as opposed to models) for medical staff bylaws have been prepared by KMA general counsel and are available at no charge to the membership; \$25 per copy for nonmembers.

Reference Committee No. 2 recommends Resolution I not be adopted.

RESOLUTION J**Mandatory Continuing Medical Education****Board of Trustees**

WHEREAS, the dedication to continuing medical education is a hallmark of the medical profession and a necessity in this age of rapidly expanding knowledge; and

WHEREAS, physicians have traditionally committed themselves to continuing education voluntarily to maintain scientific skills in the interest of enhanced patient welfare; and

WHEREAS, social and fiscal attention has focused on the lack of parity of continuing education among all practitioners of the healing arts despite irrefutable and standard evidence of physician competence; now therefore be it

RESOLVED, that KMA calls on all physicians to continue to participate in continuing medical education in a formal manner; and be it further

RESOLVED, that the Kentucky Board of Medical Licensure require participation by physicians in continuing medical education as a condition of licensure, as provided by KRS 311.601-2, and

maintain records to confirm this participation; and be it further

RESOLVED, that this participation consist of acquisition of 150 hours of CME activity within each three-year period, of which 60 hours shall be in Category 1, as designated by the American Medical Association; and be it further

RESOLVED, that such comparable activities as medical specialty board certification or CME certification by national medical specialty societies be accepted as equivalent CME participation.

Recommendations, Reference Committee 2:

Reference Committee No. 2 next considered Resolution J, Mandatory Continuing Medical Education, introduced by the Board of Trustees. Reference Committee No. 2 would like to amend the third "Resolved" by inserting "60 hours" in lieu of "150 hours" and delete "of which 60 hours shall be in Category 1, as designated by the American Medical Association."

Reference Committee No. 2 would also like to amend the fourth "Resolved" by deleting "medical specialty board certification or." The "Resolves" of Resolution J, with deletion and addition, would then read as follows:

RESOLVED, that this participation consist of acquisition of 150 60 hours of CME activity within each three-year period of which 60 hours shall be in Category 1/ as designated by the American Medical Association; and be it further

RESOLVED, that such comparable activities as medical specialty board certification or CME certification by national medical specialty societies be accepted as equivalent CME participation.

Reference Committee No. 2 recommends adoption of Resolution J, as amended. Following a lengthy discussion and a roll call vote, the motion carried.

Resolution J, adopted as amended, reads as follows:

WHEREAS, the dedication to continuing medical education is a hallmark of the medical profession and a necessity in this age of rapidly expanding knowledge; and

WHEREAS, physicians have traditionally committed themselves to continuing education voluntarily to maintain scientific skills in the interest of enhanced patient welfare; and

WHEREAS, social and fiscal attention has focused on the lack of parity of continuing education among all practitioners of the healing arts despite irrefutable and standard evidence of physician competence; now therefore be it

RESOLVED, that KMA calls on all physicians to continue to participate in continuing medical education in a formal manner; and be it further

RESOLVED, that the Kentucky Board of Medical Licensure require participation by physicians in continuing medical education as a condition of licensure, as provided by KRS 311.601-2, and maintain records to confirm this participation; and be it further

RESOLVED, that this participation consist of acquisition of 60 hours of CME activity within each three-year period; and be it further

RESOLVED, that such comparable activities as CME certification by national medical specialty societies be accepted as equivalent CME participation.

RESOLUTION K**Survey of Physicians Who Leave Kentucky
KMA Resident Physicians Section**

WHEREAS, much has been reported on the number of medical school graduates who leave Kentucky for further training and practice; and

WHEREAS, there is a current shortage of physicians in many rural and urban areas; and

WHEREAS, the KMA Physician Manpower Committee has undertaken studies in the past to examine what motivates physicians to choose either urban or rural practice; now therefore be it

RESOLVED, that KMA request the Kentucky Cabinet for Human Resources to survey out-of-state physicians trained in Kentucky, either as a medical student or a resident, to determine factors contributing to their decisions to leave the state, and to share the results with KMA, both Kentucky medical schools, and other appropriate agencies.

Recommendations, Reference Committee 2:

Reference Committee No. 2 next considered Resolution K, Survey of Physicians Who Leave Kentucky, introduced by the KMA Resident Physicians Section.

Reference Committee No. 2 recommends amending the "Resolved" by inserting "if such information is not currently available." The "Resolved" of Resolution K, with the addition, would then read as follows:

RESOLVED, that KMA request the Kentucky Cabinet for Human Resources to survey out-of-state physicians trained in Kentucky, either as a medical student or a resident, to determine factors contributing to their decisions to leave the state, and to share the results with KMA, both Kentucky medical schools, and other appropriate agencies, if such information is not currently available.

Reference Committee No. 2 recommends adoption of Resolution K, as amended.

RESOLUTION T

Increasing the Number of Primary Care Physicians Board of Trustees

WHEREAS, a current and projected shortage of primary care physicians exists in Kentucky, in addition to an overall maldistribution problem; and

WHEREAS, primary care physicians are defined as specialists in family practice, general internal medicine, general pediatrics, or medicine/pediatrics, and although it is recognized that needs exist for general surgeons, obstetricians, psychiatrists, and emergency medicine physicians, these are not included in standard definitions of primary care; and

WHEREAS, the ratio of primary care physicians to all physicians is disproportional in relation to geographic and medical care needs of the state's population; and

WHEREAS, final development of primary care physicians requires early influence during the educational process; and

WHEREAS, all principals of the medical community have an equal and related interest in achieving proportional parity among medical specialists; now therefore be it

RESOLVED, that KMA work with the medical schools to have 50% of their graduates enter primary care programs; and be it further

RESOLVED, that coordinated efforts be made to ensure that 40% of graduates enter the practice of primary care medicine; and be it further

RESOLVED, that the aid of other appropriate agencies and organizations be enlisted for this effort; and be it further

RESOLVED, that KMA actively encourage and support the strengthening of existing family practice residency programs in the state of Kentucky with regard to funding, faculty, and clinical experience.

Reference Committee No. 2 next considered Resolution T, In-

creasing the Number of Primary Care Physicians, introduced by the Board of Trustees.

Reference Committee No. 2 recommends the adoption of Resolution T.

Mr Speaker, Reference Committee No. 2 recommends adoption of the Report as a whole, as amended.

Mr Speaker, I would like to thank the other members of the Committee: Charles E. Bea, MD, Mayfield; John D. Gover, MD, Bowling Green; Michael D. Hagen, MD, Lexington; and G. Irene Minor, MD, Berea. I also want to personally thank Ms Beth Thomas for her assistance in the preparation of this report.

Respectfully submitted,

REFERENCE COMMITTEE NO. 2

Samuel G. Eubanks, Jr, MD, Louisville, Chairman

Charles E. Bea, MD, Mayfield

John D. Gover, MD, Bowling Green

Michael D. Hagen, MD, Lexington

G. Irene Minor, MD, Berea

Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE NO. 3

Andrew M. Moore, MD, Lexington, Chairman

20. Report of the Maternal Mortality Study Committee
21. Report of the Committee on National Legislative Activities
22. Report of the Committee on State Legislative Activities
23. Report of the Committee on Professional Liability Insurance
24. Report of the Committee on Impaired Physicians
25. Report of the Committee on Care for the Elderly
5. Report of the Chairman, Board of Trustees, Report of the Ad Hoc Committee to Implement Resolution M (1991), *only* Resolution L — Mandated Service Requirement for Kentucky-Trained Physicians (KMA Resident Physicians Section)
- Resolution O — Excise Tax on Tobacco Products and Discounts for Nonsmokers (Fayette County Medical Society)
- Resolution P — Restrictions on Smoking (Fayette County Medical Society)

ITEMS FOR CONSENT

Reference Committee No. 3 reviewed the following items and recommends they be filed, as indicated, by consent of the House, without discussion:

21. Report of the Committee on National Legislative Activities — Filed
23. Report of the Committee on Professional Liability Insurance — Filed
25. Report of the Committee on Care for the Elderly — Filed

Mr Speaker, Reference Committee No. 3 recommends adoption of the Consent Calendar as a whole.

Report of the Committee on National Legislative Activities

The Committee on National Legislative Activities witnessed a great

deal of activity on legislative matters related to medical care, but little final product.

Of most recent and obvious concern have been efforts in both Houses of Congress relating to so-called health care reform. In both Houses, and in committees of jurisdiction, a variety of proposals have been put forth to extend Medicare payment policies to the private sector; establish spending caps for public and private health programs; and to preempt state laws regulating managed care and utilization review programs. Also included have been insurance market reform, professional liability reform, market-based containment efforts, and changes in tax policy for health insurance coverage.

Rather than relate specifics about the various bills touching on these proposals, the summary result is that no legislation has passed. However, the intense focus on these issues mirrors that of similar efforts taking place in Kentucky. These efforts have been partially initiated because of genuine concern over continuing rising health costs and availability of services. Unfortunately, there seems to be an equal amount of empty rhetoric involved which is not based on the true issues of costs and availability, but rather on increasingly difficult economic times and an outrageous national debt.

Organized medicine's national-level answer to these difficult questions is encompassed in the AMA's Health Access America, which has been adopted in principle by KMA. This is a 22-point plan for revisions to the current medical care delivery system, including lifestyle and legislative changes, but retaining a good many provisions of the current process. The Congressionally developed proposals are somewhat more radical. However, the simple equation remains, which is that cost and availability cannot be maintained as the population's need and demand for services increases unless services are decreased and fiscal resources increased. These are unhappy truths for which no consensus has been achieved.

On more specific issues, KMA has sought support from Kentucky's Congressmen on four pieces of legislation. These are:

- HR 4507/S 2362, which would eliminate the current differential between payment to established physicians in the Medicare program as opposed to new physicians;
- HR 3373/S 810, which would provide payment for EKGs performed in physicians' offices;
- HR 4393/S 2683, which would revise Geographic Cost Practice Indices (GPCIs) under the RBRVS payment system; and
- HR 2695/S 1332, the "Anti-Hassle II" bill, which would further reduce factors in the Medicare program which are a nuisance and inconvenience to physicians.

As of this writing, cosponsorship by some Kentucky Congressmen has been achieved, and work continues to garner support for these issues.

HR 3553, the Higher Education Act bill, was passed by the House. The bill provides for student loan deferments to all classes of students and applies to those individuals in school, unemployed, or suffering financial hardship. A provision of the bill requires the Secretary of the Department of Health and Human Services to consider the debt-to-income ratio of students in writing regulations.

Other selected legislative issues have included HR 3750, which would place a spending limit on Congressional races of \$1 million, and S 3, which would prohibit Political Action Committees from contributing to federal elections. Efforts are underway to stifle both of these provisions. HR 3508 has passed both Houses and would establish the AMA's National Credentialing Verification Service as the authority for credentialing international medical graduates.

Other issues have included AMA's ongoing meetings with the Executive Branch on OSHA regulations relating to blood-borne

pathogens. The intent here is to mitigate zealous and arbitrary inspections and to delay sanctions until physicians have the ability to respond to inspections. Regulations implementing the Clinical Laboratory Improvement Act continue to be implemented. The most recent will require physicians' offices to encounter the initial regulatory phase beginning September 1. AMA continues to work within the Executive Branch to address arbitrary provisions on the nature and volume of tests covered under the regulations. More locally, KMA has worked with members of the Kentucky Delegation to continue funding for AIDS research and treatment centers, nationally, and particularly those which provide new and experimental treatments to Kentucky patients.

Congressional activity relating to medical care issues will continue to be volatile for the remainder of this Congress, and will reflect the frustrations of the members of those bodies. While there is a great deal of focus on health care reform, the actual success of any particular measure is dubious because of the upheaval that will occur in the Congressional makeup in this election cycle. Of paramount importance to medicine is that each individual physician maintain active contact with his or her Congressman and support KMA's central legislative efforts.

Donald C. Barton, MD
Chairman

Report of the Committee on Professional Liability Insurance

The Kentucky Medical Association continues its quest for tort reform. While we have great concern with the Special Session on Health Care Reform, particularly the proposal to establish fee schedules, the fact that the Governor has also included tort reform gives us some optimism. While we have not been successful in obtaining the Constitutional amendment to limit noneconomic awards, it is nonetheless important that we keep the pressure on our adversaries. Experts, including most professional liability insurance companies, are forecasting a return of the vicious cycle of large awards and increasing numbers of lawsuits against physicians.

During the 1992 session, ten bills were introduced relating to professional liability. On pages 18-19 of the 1992 KMA Legislative Report mailed with the July issue of the *KMA Journal*, you will find a summary of each legislative proposal. Of all the bills introduced during the 1992 session, HB 322 had the greatest potential for harm. HB 322 redefined loss of consortium to allow a claim for a child or parent when one or the other is injured or killed. The bill literally flew through the House of Representatives but, with great support from business and insurance groups, we were able to slow it down in the Senate Judiciary Committee.

Two other bills which concerned us were HB 757, which altered the statute of limitations in malpractice actions from one year to one-and-a-half years, and SB 38, relating to wrongful death cases. We were able to keep these in the committees without even a hearing being conducted.

We made every effort to press the tort reform program before the General Assembly and the public. During the Associational year, we contracted with the Gallup Organization to conduct a poll of Kentuckians. Our main focus was on citizens' attitudes toward tort reform and whether or not they would support us in our efforts. An overwhelming number of Kentuckians reaffirmed our 1982 poll which showed that over 71% of Kentuckians believed that a cap should be placed on noneconomic awards. We intend to use the complete results of the 1991 Gallup poll during the upcoming special session.

On the federal level, both the Administration and Congressional bills dealing with health costs include major malpractice reform. We are working very closely with AMA and the Kentucky Congressional Delegation to effect reform on the federal level.

A packet of information has been forwarded to the Legislative Research Commission spelling out the need for tort reform. In addition, "The KMA Plan," which has been presented to the Commission on Health Care Reform, contains a special section dealing with reform of the medical liability program.

In January 1992, KMA co-sponsored with the Kentucky Chamber of Commerce, a legislative reception for members of the Kentucky General Assembly. In mid-January 1992, we conducted an excellent Legislative Seminar in Frankfort. Members of the Kentucky General Assembly participated in the Seminar, along with both House and Senate Chairmen of the Health and Welfare Committees. Participants in attendance included KMA Key Legislative Contacts, Specialty Group Presidents, Auxiliary leadership, KEMPAC Board of Directors, KMA Board of Trustees, and medical executives.

We continue to work very closely with the Tort Reform Association of Kentucky (TRAK), which is comprised of over 50 major businesses and associations in Kentucky. William E. (Bill) Doll, Jr, former KMA staff counsel and present legislative legal counsel, heads up TRAK.

Once again, we provided every KMA member a legislative Handbook and a complete summary of the session. In addition, we mailed a "Legislative Bulletin" to every KMA member on a weekly basis during the session. We believe the Committee on PLI has had an extremely successful session, and I want to thank the members of the Committee for their commitment and hard work throughout the session. We have made every effort to keep the membership informed and to have an inclusive program. Thank you for the opportunity you have given me, and I sincerely hope that the upcoming special and regular sessions will provide some relief for the growing malpractice crisis.

Wally O. Montgomery, MD
Chairman

Report of the Committee on Care for the Elderly

The Committee on Care for the Elderly continued its efforts this year to encourage educational activities on behalf of geriatric medicine, to maintain liaison with geriatric patient groups, and to develop rapport within the profession on issues related to aging.

The Committee is in the process of reviving the Kentucky Medical Directors Association. In past years, this Association, which has a national counterpart, existed to serve physician directors of nursing homes. In the more recent past, the organization had become dormant, but with increasing legislation affecting nursing homes and physicians, it was felt appropriate for it to resume its efforts. To date, over 100 physicians have been identified who have an interest in this activity. Discussions have also been held concerning certification of local medical directors, patterned on similar efforts initiated in Minnesota.

On a related issue, Committee members individually remain active in the Kentucky Geriatrics Society (KGS), which the Committee helped found. The KGS has held organizational and educational meetings during the last two KMA Annual Meetings, and another is planned for the upcoming meeting in September, including a function with the Kentucky Medical Directors Association.

Previously, the Committee has conducted seminars for representatives of various organizations involved with or representing

elderly patients. Last year, a particularly productive seminar was conducted entitled "Forum on Driving Impairment." A number of enlightening issues were addressed by a knowledgeable physician, state legislators, and a representative of the State Police. In follow up, the Committee intends to offer its assistance to the State Police in conducting free seminars on driving safety and to provide other medical input.

The Committee is currently working on plans to develop another forum concerning the cost and availability of drugs. Tentatively, participants would be major health insurers, representatives from pharmaceutical manufacturers, pharmacists, and legislators. The purpose of this seminar will be to include in discussions issues of generic substitutions, the role of insurance companies with regard to long-term prescriptions, and the role of pharmacists as advocates for patients.

In line with this seminar, the Committee considered Resolution O, Large-Quantity Prescriptions, which was adopted by the 1991 House of Delegates and referred to the Committee. The Resolution expresses concern over insurance requirements for large-quantity prescriptions. Specifically, there were concerns that patients might not take medications as prescribed, which could lead to complications or overdose. It was felt that this Resolution could best be considered in the context of the forum on drugs that is being planned.

A number of issues were reviewed relating to the Medicare program and negative effects, socially and medically, on elderly patients. Of particular concern was the effect of Resource-Based Relative Value Scale reimbursement to primary care and geriatric care physicians. These dynamics were seen to have negative impact on physician-patient relations and potential access to care by elderly patients.

The Committee will continue its efforts relating to education and patient advocacy and appreciates the opportunity to serve the Association in this regard.

John C. Wright, II, MD
Chairman

END OF CONSENT CALENDAR ITEMS

Report of the Maternal Mortality Study Committee

The Maternal Mortality Study Committee met once during the orga-

MATERNAL MORTALITY STUDY TABLE	
Obstetrics Indirect	Preventable Factor
	Asthmatic Disease
Non-Obstetrics	Preventable Factor
	Head Trauma
Non-Obstetrics	Preventable Factor
	Strangulation
Obstetrics Indirect	Non-Preventable
	Cardiac Ventricular Fibrillation
Obstetrics Direct	Non-Preventable
	Cardiomyopathy
Obstetrics Direct	Preventable Factors
	Severe Pre-eclampsia
	Cerebrovascular
	Hemorrhage related to a Basilar Aneurysm

nizational year, November 7, 1991, at the Galt House West in Louisville. The cases presented were discussed, evaluated, and classified as shown in the accompanying table. The case of cardiomyopathy has been presented to the *KMA Journal* for publication.

It is gratifying to observe a continuing decline in maternal mortality in Kentucky as well as in the USA (*Obstetrics and Gynecology*, 76:1055, 1990). Records on maternal mortality activity in Kentucky have been maintained since prior to 1960, and this information will be tabulated and presented to KMA for publication in the *Journal*. Although reports have been submitted each year, the Committee feels a 30-year tabulation and study should be documented.

John W. Greene, MD
Chairman

Recommendations, Reference Committee 3:

Reference Committee No. 3 reviewed the Report of the Maternal Mortality Study Committee and thanks the Committee for its report. Reference Committee No. 3 believes it may be worthwhile for KMA to form a separate committee to study infant mortality and fetal death.

Reference Committee No. 3 recommends the adoption of the Report of the Maternal Mortality Study Committee.

Report of the Committee on State Legislative Activities

The 1992 Report of the Kentucky General Assembly, a special supplement to the July issue of *The Journal of the Kentucky Medical Association*, shall serve as the official report of the Committee on State Legislative Activities to the 1992 House of Delegates. This addendum to that report will clarify action taken or referrals to the Committee by the Board of Trustees of House of Delegates 1991 reports and Resolutions.

Resolution E — Access to Tobacco by Children

Resolution E recommended that KMA support legislation to:

- A. Oppose use of billboards which advertise tobacco products visible from school property (K-12).
- B. Restrict usage of tobacco vending machines to persons over 18 years of age.
- C. Require local health departments to provide free smoking cessation clinics to children under age 18 in areas where clinics are unavailable.
- D. Restrict smoking on school property during school hours to adult employees.

Representative Anne Northup (R) of Louisville introduced HB 352, adopted by the Kentucky General Assembly. HB 352 prohibits providing cigarette samples to persons under age 18; restricts billboards larger than 50 square feet which advertise tobacco from being placed within 500 feet of an elementary or secondary school; prohibits "knowingly" selling tobacco to persons under the age of 18. KMA will continue working with various other groups to implement Resolution E.

Legislation to prohibit students in grades 7-8 from participating in varsity soccer, football, and wrestling.

The passage of HB 443 in 1990 allowed students in grades 7-8 to participate in *all* varsity sports. The Committee on School Health, Physical Education, and Medical Aspects of Sports recommended that this legislation be amended to exclude younger students from

participating in varsity contact sports, ie, soccer, football, and wrestling, unless they have completed the 8th grade.

Representative Jody Richards (D) of Bowling Green, introduced HB 750 on behalf of KMA. Representative Richards' legislation now permits the Department of Education to regulate this activity and restrict participation in these sports to children who have successfully completed the 8th grade.

Resolution Q (1990) — Legislative study of water jet skis and boat/water safety.

HBs 30, 100, 169, 177, and SB 256 all related to either study or passage of boat/water safety legislation. Although KMA supported passage of these bills, none cleared the legislative process.

Resolution P — Medicare Supplement Regulations

This Resolution opposed Kentucky's participation in the Medicare-select policy adopted by the National Association of Insurance Commissioners (NAIC) and requested consideration of legislative, administrative, and regulatory methods to exclude Kentucky's participation.

Prior to convening of the 1992 session, regulations were adopted which included Kentucky under NAIC guidelines. After careful review of the Resolution, and based upon consultation with legal counsel, we elected not to submit legislation to exclude Kentucky from federal requirements at this time. Members of the General Assembly generally supported the regulations along with most insurance companies, public activist groups, and other health care provider groups. As the opportunity presents itself, we will attempt to meet the objectives of Resolution P. We will continue to monitor this situation and communicate our concerns as they arise to our elected representatives.

The Committee met on two occasions during the 1991-92 year. Our first meeting in Louisville was extensive as we prepared for the 1992 session. Various groups appeared before the Committee and we reviewed several prefiled bills. At the second meeting in Frankfort, we discussed the various bills that were being considered during the session and then spent considerable time on the upcoming special session on health care and KMA's position on several controversial topics. The Committee discussed numerous subjects, including prescribing by physician extenders, mandating CME for physicians, CON for physicians' offices based upon equipment costing \$250,000 and above, and self-referral. Due to the Governor's call for a special session, the above issues were reported directly to the Board of Trustees and various recommendations were adopted or referred by the April Board of Trustees to address them. The House of Delegates will review and reconsider KMA's position on these matters.

During the 1992 session, the Quick Action Committee met weekly in Frankfort to review legislation, establish positions, and direct the KMA lobbying team.

We move toward the special session on health care reform with great trepidation. I fear that most physicians do not comprehend the full potential and ramifications the special session may have on medical practice in Kentucky. The terms "cutting edge" and "avant-garde" are utilized extensively by the administration and media to characterize their views on reforming Kentucky's health care system. When you consider what has been done in Minnesota, Vermont, Florida, and other states, it causes one to pause and wonder what they mean by being on the "cutting edge" of health reform. In addition, with the combination of the legislative/lobbying scandal and inclusion of legislative ethics in the same session with reform of the health care system, the situation is compounded.

I feel that we have the best and most ethical lobbying team in Frankfort. In no way has there been any complaint from the legislature or other lobbyists that our team has been involved in unethical conduct. I want to assure the membership of KMA that we will work any way we can with the ethics legislation to insure that we have input into the evaluation of lobbyists and how they should function in Frankfort.

The special session ought to take great precedence in the next three months, as KMA's success or failure will be determined by what you do on the local level with your legislators. The General Assembly will be under tremendous pressure to "go along" with the administration and legislative leadership proposals. We wrote a special letter asking each of you to contact your legislators and ask that they discuss with you the final product before committing. Extraordinary efforts have been made by KMA to develop a plan for change and to educate patients, legislators, and physicians. We are preparing legislative packets and patient brochures, and will utilize any other method we can to assure that patient care is not threatened under the guise of "health care reform." We need to be realistic and especially mindful of those issues that are obviously self-serving, do not contribute to patient care, and may drive the cost of medical care upward. I have been extremely impressed by members of the KMA Board of Trustees. They have been very open to change and have assumed a leadership role.

Our goal is to preserve quality of patient care and assure that we maintain the ability to practice free of unnecessary restraints. Thank you for your confidence and for the continuing assistance you provide to the legislative effort.

Wally O. Montgomery, MD
Chairman

Recommendations, Reference Committee 3:

Reference Committee No. 3 reviewed the Report of the Committee on State Legislative Activities. Reference Committee No. 3 commends Wally O. Montgomery, MD, and the Committee for its time and the tremendous amount of work in preparing this report. The Reference Committee encourages the KMA membership to support this Committee during the 1992 Kentucky General Assembly Special Session on Health Care Reform.

Reference Committee No. 3 recommends the adoption of the Report of the Committee on State Legislative Activities.

Report of the Committee on Impaired Physicians

This has been a particularly active year for the Committee on Impaired Physicians. While the Committee has continued to work toward expansion of its efforts to address more sophisticated monitoring and treatment concerns, routine activities continue to grow exponentially. Increased activity with external organizations also occurred this year.

The Committee enjoyed increased liaison with the Board of Medical Licensure. Nearly all referrals came from the Board of Licensure this year. These referrals consisted of physicians seeking to relocate from other states, physicians in training, and physicians with impairments who came to the attention of the Board from other sources. These referrals result in a closer information exchange with the Board. While the Board relies on the Committee for monitoring of aftercare activities, the Committee, likewise, depends on the Board for investigation contacts and some body fluid screens. To confirm these increased joint efforts, Committee representatives routinely meet with the Licensure Board to exchange information with its investigatory units and legal section.

Some efforts were expanded this year which are fairly unique as compared with other impaired physicians programs in the country, and as they relate to substance abuse aftercare in general. The Committee has initiated two physician therapy groups for individuals who have recently emerged from acute treatment and hopes to help in the development of two more groups by the year's end. The Committee has also helped initiate a family therapy group, which is available to all individuals who seek the Committee's help. These therapy activities are directly monitored by the Committee and are run by qualified alcohol therapy counselors of prudent experience with input by psychiatrists with acknowledged expertise. One result of the increased emphasis on therapy has been a reduced rate of relapse.

The Committee's activities as an advocate for recovering individuals have assumed a high profile. Routinely, the Committee provides this advocacy to the Licensure Board, hospital medical staffs, liability insurance carriers, physician practice groups, and health insurance carriers. This advocacy does not take the form of simple acknowledgement that an individual is working with the Committee but, rather, detailed information is routinely supplied concerning the individual's specific recovery regimen and body fluid testing results. Often this requires face-to-face transmission of information.

An indirect portion of this advocacy also includes intervention in instances of relapse which, fortunately, are not frequent, and coordination with affected agencies in the event of relapse to mutually develop future treatment of the affected individual. While the Committee is abhorrent of punitive measures, a recovery program of rigorous honesty demands that individuals and organizations affected by an impaired physician be kept fully informed of the individual's recovery status. This "tough love" philosophy is often painful, but necessary to the commitment to honesty for the safeguard of patients and, in the long-term, the best interests of the recovering physician.

As these activities have increased, the need for a medical director program seems more apparent. In April, the Board of Trustees approved a proposal to seek the input and financial commitment of the Board of Medical Licensure to help fund medical director activities. The Board of Medical Licensure, likewise, approved the principles of a commitment to assist in funding, a more formalized referral of physicians to the impaired physicians program, and revision of the licensure law to provide liability protection to individuals working in the field.

With the approval of both boards, work has begun to develop a private, autonomous, nonprofit organization, which would be governed by a Board of Directors composed of seven individuals. These individuals would represent the KMA Board of Trustees, the Impaired Physicians Committee, the Board of Medical Licensure, and consumers, with a majority of members being appointed by KMA. The Board of Directors would employ a medical director who would be under the day-to-day direction of the Impaired Physicians Committee, and the Foundation could solicit funds from a variety of sources to accomplish its tasks. Currently, work is underway to seek nonprofit status from the Internal Revenue Service, and incorporation procedures are underway.

In the midst of all of the activity recited, the Committee is resolved to retain its commitment to the fundamentals of recovery and assistance to brother physicians. Organizational expertise continues to develop, but all measures stem from the tenets of recovery, and that remains the basic and sole goal of all of these efforts. For this reason, the continued input and assistance of the Committee members, other recovering physicians, and all others with a simple,

but strong concern for benevolence are crucial.

As Chairman, I would like to state my humble and sincere thanks to the Committee members for all their work, to the Board of Trustees for its support, and to all other organizations and individuals who have so steadfastly expressed their intent to be "their brother's keeper."

Burns M. Brady, MD
Chairman

Recommendations, Reference Committee 3:

Reference Committee No. 3 reviewed the report of the Committee on Impaired Physicians and recognizes the extraordinary success of the Committee in assisting physicians in the recovery from alcohol and drug abuse. Reference Committee No. 3 encourages the Committee on Impaired Physicians to explore the possibility of including in its program physically handicapped physicians and their need for alternative career choices.

Reference Committee No. 3 recommends the adoption of the Report of the Committee on Impaired Physicians.

Report of the Ad Hoc Committee to Implement 1991 Resolution M (Do Not Resuscitate)

Addendum to the Report of the Chairman, Board of Trustees

The Ad Hoc Committee to Implement 1991 Resolution M (Do Not Resuscitate) was formed after the adoption of the Resolution by the 1991 Kentucky Medical Association House of Delegates. Resolution M calls for the Kentucky Medical Association to:

- work with representatives of appropriate professional groups and organizations, as well as government and regulatory authorities, if necessary, to develop a uniform, coordinated, and rational approach with respect to the terminally ill patient who does not wish to be resuscitated or to receive extraordinary life-prolonging treatment in the pre-hospital environment;
- develop a standard prehospital DNR form and to pursue statewide acceptance of this form by means of education;
- seek the necessary legislative and regulatory changes to protect the patient's right to self-determination, as well as to protect the activities of those health care professionals who follow such directives;
- work toward development of a statewide, standardized, reasonable method for the immediate identification of patients who have a valid DNR order in effect.

Most EMS systems use the American Heart Association Guidelines for the initiation of cardiopulmonary resuscitation (CPR). Under that protocol, all pulseless and nonbreathing patients receive cardiopulmonary resuscitation, except those meeting specific criteria for irreversible death. Strict application of this rule frequently leads to care which may be inappropriate in cases of individuals in the end stages of a terminal illness. Therefore, the EMS provider is often put at odds with families who desire no CPR, but who, in the stress of nearing death of a loved one, called 911. Living Wills and the use of Do Not Resuscitate (DNR) documents in the hospital do not address the problems of the EMS providers outside the hospital setting. Kentucky has no standard DNR protocol, and each hospital develops its own guidelines.

A major task of the Committee is to develop a standard form

as well as other systems that could identify a terminally ill patient in the out-of-hospital situation that could be recognized by EMS providers statewide; ie, a bracelet system. Physician DNR guidelines need to be developed and made uniform. Current Living Will and Health Care Surrogate Acts should be amended to allow inclusion of prehospital DNR orders and to provide immunity for providers. A mechanism for prehospital validation of a DNR order or Living Will declaration needs to be implemented.

Other tasks the Committee will confront include defining the term "terminally ill" and developing a hierarchy of decision makers in those instances when the patient is incapacitated and therefore unable to understand and consent to the DNR order. The Committee has studied definitions of "terminally ill" used by other states and has decided that the definition should include those persons who are in the end-stages of a disease when curative measures are not appropriate, and comfort rather than life-prolonging treatment is warranted. The Committee determined that requiring determination that death will occur within a specific period of time was not warranted. Therefore, the definition is broader than that in the existing Living Will and Health Care Surrogate statutes which requires a determination that death will occur within a few days.

The Committee further examined the problem faced by medical personnel when the patient is incompetent and therefore unable to understand and make a determination to agree with the DNR order. The Committee is attempting to develop a hierarchy of family members and/or a court-appointed guardian in order to make this decision for the incompetent patient. The Committee understands that a similar amendment proposed for the Living Will and Health Care Surrogate statutes failed to be adopted after facing considerable opposition during the 1992 General Assembly. Without such a decision making hierarchy, however, any DNR legislation would be limited in the number of patients which would be subject to its benefits.

The Committee's goal is to seek legislation during an upcoming session of the Kentucky General Assembly. The Committee noted that it may not be feasible to attempt to obtain the required legislation in the 1992 special session. The Governor must put the issue in a "call" in order to be considered. It should be noted that achieving the goal of getting prehospital DNR legislation through the Legislature will require a considerable effort in light of the defeat of amendments to the existing Living Will and Health Care Surrogate statutes during the 1992 General Session. It is noted that the end result of bringing this issue to the attention of the General Assembly may mean more restrictions on how to treat terminally ill patients in hospitals.

The Committee has studied legislation adopted in states such as North Carolina, New York, and others which extend DNR orders to prehospital settings. Only four other states have such laws in place. The Committee is currently preparing an initial draft of legislation.

The Committee feels that in order to pass legislation there must be a common ground among interested organizations. In the coming months the Committee will attempt to gain support of other health care organizations including, but not limited to, Hospice and the Kentucky Association of Older Persons.

As Chairman, I would like to thank the Committee members for sacrificing their time and effort in order to make this project a success.

James R. Bean, MD
Chairman

Recommendations, Reference Committee 3:

Reference Committee No. 3 reviewed the Report of the Chairman, Board of Trustees, Report of the Ad Hoc Committee to Implement Resolution M (1991), *only* and acknowledges the extensiveness and difficulties of this complex issue which will require the attention of the Kentucky General Assembly.

Reference Committee No. 3 recommends the adoption of the Report of the Ad Hoc Committee to Implement Resolution M (1991).

Resolution L

Mandated Service Requirement for Kentucky-Trained Physicians

KMA Resident Physicians Section

WHEREAS, medical students have to complete further training upon graduation of at least one to up to seven or eight years before going into practice; and

WHEREAS, a large percentage of medical school graduates leave Kentucky to pursue this extended training; and

WHEREAS, there is already concern with meeting mandated quotas within each class and concern with the current applicant pool of residents; and

WHEREAS, proposals to require medical graduates to stay in Kentucky for two years would only exacerbate this situation; now therefore be it

RESOLVED, that the Kentucky Medical Association oppose any legislative proposals that institute a mandated service requirement for physicians trained in Kentucky.

Recommendations, Reference Committee 3:

Reference Committee No. 3 considered Resolution L, Mandated Service Requirement for Kentucky-Trained Physicians, introduced by the KMA Resident Physicians Section. The Reference Committee received input from the Board of Trustees and interesting and informative comments from several physicians on Resolution L. Reference Committee No. 3 recommends the following substitute wording be adopted in lieu of this existing "Resolved":

RESOLVED, that the Kentucky Medical Association oppose any legislative proposals that institute a mandated an involuntary service requirement for physicians trained in Kentucky.

Reference Committee No. 3 recommends the adoption of Resolution L as amended.

RESOLUTION O

Excise Tax on Tobacco Products and Discounts for Nonsmokers

Fayette County Medical Society

WHEREAS, smoking is the leading cause of preventable death in the US; and

WHEREAS, Kentucky leads the nation in the prevalence of smoking, smoking-attributable mortality, and years of potential life lost due to smoking; and

WHEREAS, both economic incentives and legal restrictions are effective in reducing tobacco consumption; and

WHEREAS, more than \$22 billion of the \$90 billion in annual Medicare expenditures for health care in Kentucky is attributable to cigarette smoking, and 28% of this cost is paid for by Kentucky state dollars, which means that although fewer than 30% of Kentuckians smoke, all Kentuckians are paying for the higher health care costs of smokers; and

WHEREAS, differential insurance premiums also encourage

nonsmoking and generate revenue from a group of people who are likely to incur extra health costs because of their lifestyles; and

WHEREAS, the KMA and its constituent members are committed to reducing preventable deaths and illness among citizens of the Commonwealth; now therefore be it

RESOLVED, that the KMA work for the passage of the following legislative issues in the 1992 Special Session of the General Assembly on Health Care Reform:

- 1) To increase the excise tax on the sale of a package of cigarettes to the national median and to tax other tobacco products not currently taxed;
- 2) To require insurance companies to offer premium discounts for nonsmokers.

Recommendations, Reference Committee 3:

Reference Committee No. 3 next considered Resolution O, Excise Tax on Tobacco Products and Discounts for Nonsmokers, introduced by the Fayette County Medical Society and heard extensive discussion regarding the importance of reducing preventable deaths among citizens of Kentucky. While Reference Committee No. 3 agrees with the concept of Resolution O, it is recommended the following amendments be made in the language:

RESOLVED, that the KMA work for the passage of the following legislative issues in the 1992 Special Session of the General Assembly on Health Care Reform:

1. **To increase the excise tax on the sale of a package of cigarettes to the national median and to tax other tobacco products not currently taxed.**
- 2/ ~~To require insurance companies to offer premium discounts for nonsmokers.~~

Reference Committee No. 3 recommends that Resolution O be adopted as amended.

A motion was made from the floor to further amend the recommendation of the Reference Committee by changing the words "1992 Special Session" to the words "next and subsequent Sessions," and deleting the words "on Health Care Reform," which would cause the sentence to read, "Resolved, that the KMA work for the passage of the following legislative issue in the next and subsequent Sessions of the Kentucky General Assembly." The motion was seconded from the floor and carried.

A motion was then made from the floor to add a second Resolved to read, "Resolved, that the additional funds raised through this excise tax be used to fund health care in the Commonwealth of Kentucky." The motion was seconded and carried.

Resolution O, adopted as amended in its final form, reads as follows:

WHEREAS, smoking is the leading cause of preventable death in the US; and

WHEREAS, Kentucky leads the nation in the prevalence of smoking, smoking-attributable mortality, and years of potential life lost due to smoking; and

WHEREAS, both economic incentives and legal restrictions are effective in reducing tobacco consumption; and

WHEREAS, more than \$22 billion of the \$90 billion in annual Medicare expenditures for health care in Kentucky is attributable to cigarette smoking, and 28% of this cost is paid for by Kentucky state dollars, which means that although fewer than 30% of Kentuckians smoke, all Kentuckians are paying for the higher health care costs of smokers; and

WHEREAS, differential insurance premiums also encourage nonsmoking and generate revenue from a group of people who are likely to incur extra health costs because of their lifestyles; and

WHEREAS, the KMA and its constituent members are committed to reducing preventable deaths and illness among citizens of the Commonwealth; now therefore be it

RESOLVED, that the KMA work for the passage of the following legislative issue in the next and subsequent Sessions of the Kentucky General Assembly:

1. To increase the excise tax on the sale of a package of cigarettes to the national median and to tax other tobacco products not currently taxed; and be it further

RESOLVED, that the additional funds raised through this excise tax be used to fund health care in the Commonwealth of Kentucky.

RESOLUTION P

Restrictions on Smoking Fayette County Medical Society

WHEREAS, smoking is the leading cause of preventable death in the US; and

WHEREAS, Kentucky leads the nation in the prevalence of smoking, smoking-attributable mortality, and years of potential life lost due to smoking; and

WHEREAS, both economic incentives and legal restrictions are effective in reducing tobacco consumption; and

WHEREAS, the KMA and its constituent members are committed to reducing preventable deaths and illness among citizens of the Commonwealth; now therefore be it

RESOLVED, that the KMA support the following legislative issues in the 1992 Special Session of the General Assembly on Health Care Reform:

1. To enact a clean indoor air standard, applicable to all public buildings in the Commonwealth and all buildings which are open to public access, which restricts smoking to designated areas which are separately vented to the outside;
2. To require all school districts to ban smoking from all school buildings and school-sponsored events involving students;
3. To ban the sale of tobacco products in vending machines except in areas that are off limits to minors or are operated with tokens which can be acquired only by adults;
4. To include tobacco use rates and tobacco-related knowledge levels as evaluation criteria for schools under the framework of education reform;
5. To ban tobacco company sponsorship of athletic events in which youth are involved;
6. To provide that, in order to sell tobacco products, a retailer must have a license (similar to a liquor license) which can be revoked for sales to minors;
7. To ban distributions of free tobacco product samples altogether as part of retail license requirements;
8. To restrict tobacco advertising to black-and-white printed text without pictures (the "tombstone" law), if permissible under federal law or regulations;
9. To repeal the "smokers' rights" provisions passed in 1990 which forbid consideration of smoking practices as a legitimate factor in employment decisions.

Recommendations, Reference Committee 3:

Reference Committee No. 3 reviewed Resolution P, Restrictions on Smoking, introduced by the Fayette County Medical Society and recommends the following revision in the "Resolved":

RESOLVED, that the KMA support the following legislative issues in the 1992 Special Session of the General Assembly on Health Care Reform, next and subsequent Sessions of the Kentucky General Assembly:

Reference Committee No. 3 recommends the adoption of Resolution P, as amended.

Mr Speaker, Reference Committee No. 3 recommends the adoption of the Report of Reference Committee No. 3 as a whole, as amended.

Mr Speaker, I wish to thank the members of Reference Committee No. 3 for their participation in the review of these issues. Members of the Committee are David H. Bizot, MD, Louisville; Jackson O. Pemberton, MD, Hebron; and William D. Pratt, MD, London. Reference Committee No. 3 would also like to express its appreciation to Jeanette Thompson for her assistance in preparing this report.

Respectfully submitted,

REFERENCE COMMITTEE NO. 3

Andrew M. Moore, II, MD, Lexington, Chairman

David H. Bizot, MD, Louisville

Jackson O. Pemberton, Jr, MD, Hebron

William D. Pratt, MD, London

Report of the Chairman KEMPAC Board of Directors

Mr Speaker, Fellow Delegates: It is a pleasure for me, as Chairman of the KEMPAC Board of Directors, to give you a report of KEMPAC activities for this past year.

Appointed by the KMA Board of Trustees, KEMPAC supports candidates who share our philosophy and concerns with regard to legislation that affects the Medical profession and *quality patient care*. We win friends during political campaigns by helping in many ways. When our *Views* are made known to a candidate, along with *Financial Support* and *Volunteer Work* during their campaign, it is remembered after they take office.

We are pleased to announce that due to your support this year, KEMPAC contributed over \$65,000 to State candidates in the Primary and General Election. This money was contributed early in the Primary and additional funds will be provided to candidates in the General Election. We were able to give substantial support to *Key Legislative* races. Support for these races were decided upon at the Board of Director's meeting Tuesday morning, September 15th.

On the National level, at KEMPAC'S request, AMPAC has contributed in excess of \$15,000 to Kentucky candidates for the US Senate. Together, KEMPAC and AMPAC were able to contribute over \$80,000 to candidates in the Primary and General Election this year.

I must emphasize that although KEMPAC-AMPAC funds are given in the name of Kentucky physicians, your individual support as a physician on the *local* level is very important, if not the most important factor!

Our current membership for 1992 is 845. In February, a membership promotion letter was signed by each representative on the KEMPAC Board from all Congressional Districts encouraging doctors who had not contributed to KEMPAC for 1992 to better support the candidates of this election year, *especially* with all of the vital changes taking place this election year. We received a tremendous response from concerned physicians and their spouses. The KEMPAC Board of Directors recommends that you reaffirm and include the billing of KEMPAC-AMPAC dues in the statewide billing of 1993 KMA dues, and also include "second reminder" statements of KEMPAC statements with KMA "reminder" statements later in the billing cycle. (The Motion was seconded from the floor and carried.)

This is a very crucial time for all of us, and now more than ever we need to join as one.

On behalf of the KEMPAC Board, I want to thank you delegates and the KMA Board of Trustees for your continued support.

Thank you.

Samuel Jerry King, MD

Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE NO. 4

K. Thomas Reichard, MD, Louisville, Chairman

26. Report of the Committee on Medical Insurance and Prepayment Plans
27. Report of the Committee on Claims and Utilization Review
28. Report of the PRO Advisory Committee
29. Report of the Committee to Investigate Changing Trends in Medicine
 - Resolution H — Medication Labeling
(Floyd County Medical Society)
 - Resolution N — Education of Students on the Hazards of Ultraviolet Radiation (Tanning Rays)
(Floyd County Medical Society)

ITEMS FOR CONSENT

Reference Committee No. 4 reviewed the following items and recommends they be filed, as indicated, by consent of the House, without discussion:

26. Report of the Committee on Medical Insurance and Prepayment Plans — filed.
 27. Report of the Committee on Claims and Utilization Review — filed
 28. Report of the PRO Advisory Committee — filed
- Mr Speaker, Reference Committee No. 4 recommends adoption of the Consent Calendar as a whole.

Report of the Committee on Medical Insurance and Prepayment Plans

The Committee on Medical Insurance and Prepayment Plans met in December, but the results of that meeting kept your Chairman and staff busy all year.

State Employee Health Plan — Jim Utter, General Counsel for the Kentucky Department of Personnel, and Mary Lu Dempsey, Health Insurance Administrative Manager, Department of Personnel, participated in the December meeting. Ms Dempsey and Mr Utter had been invited to the meeting in follow up to discussions held at the August Board meeting regarding the state's policy of reimbursing HMOs at a lower rate than traditional plans. The concern voiced about this practice was that it could lead to pressure by HMOs to have participating physicians lower their rates since HMOs will be collecting fewer premium dollars from the state.

Mr Utter reported on the actions which led up to this policy. When the state made the decision to self-insure four or five years ago, it had no data base on which to rely. As a result, a certain amount of money was designated for each employee to pay for insurance premiums and that amount was paid to both HMOs and

to Kentucky Kare participants. The Kentucky Kare participants were self-insured by the state, and while contracts were obtained with most Kentucky hospitals, Kentucky physicians were paid their usual and customary fee.

As the state developed its data base, it became apparent that HMOs were covering younger and healthier state employees whose utilization was significantly lower than those in the Kentucky Kare plan. One of the reasons was that HMOs operated in areas of higher competition and could arrange for deeper discounts from hospitals and physicians. Other areas of the state had no access to HMO providers. In 1991, the state brought in outside actuarial consultants and determined that HMOs were making what the state felt to be high profits because they insured younger and healthier people with less utilization while being paid at the same premium rating as Kentucky Kare, which was insuring a broader base of people including those with higher health risks. As a result, the state decided that it would differentiate in terms of the payments made to HMOs. The Committee felt no further action was necessary regarding this issue.

Ms Dempsey reported on changes in the Kentucky Kare plan. A new prenatal plan has been added which is designed to help detect high-risk pregnancies and provide education on proper prenatal care. Incentives include: payment of a higher portion of the deductible the earlier an expectant mother reports her pregnancy, provision of a copy of the *New Life Book*, and a certificate redeemable for an infant car seat. Well baby care is extended to \$200 for infants up to 24 months of age. In the standard select program, birth control pills are covered the same as other prescription drugs, and an incentive package for early maternity discharge has been added. Pap smears are covered annually for those aged 30 and up; mammograms are covered to an extent, as is rectal/sigmoidoscopy at age 50 and every year thereafter. Cardiac risk profile blood tests are covered beginning at age 35 and every five years thereafter, and EKGs are covered at age 40 and every year thereafter.

KMA Blue Cross and Blue Shield Plan — One of the Committee's assignments is to monitor the utilization of the Blue Cross and Blue Shield health plan that KMA endorses for the membership. The utilization of this plan and its premiums continue to escalate and cost stabilization efforts recommended by the carrier have had only limited success.

Teresa Madison, Account Executive, Blue Cross and Blue Shield, and Don Everingham, Vice President of Association Sales, Blue Cross and Blue Shield, met with the Committee to discuss the plan's utilization over the past year and to present 1992 rates.

Throughout the 1991 Associational year, your Chairman and staff held numerous meetings with Blue Cross and Blue Shield management to discuss what steps might be taken to make the KMA group plan a more attractive benefit and to enlarge the enrollment base. A number of options were discussed in concept.

As a first step, Blue Shield underwrote a survey of 150 KMA members currently enrolled in the Blue Cross and Blue Shield plan and 150 members who did not have the coverage. The goal of the survey was to obtain the perceptions of the plan by current enrollees and find out why members left the KMA plan and where they went to get new coverage.

The survey results indicated that the KMA plan is composed of mostly older physicians with smaller practices. Fifty-four percent of those in the KMA plan are 50 years or older and have an average of five employees. Those in the plan and those outside the plan generally felt the KMA plan was more expensive. Twenty-one percent of those not in the KMA plan had been in it at one time but dropped it due to cost. Thirty percent of those not in the plan were

unaware that a KMA group program was available. Twenty-five percent of those surveyed do not offer any insurance coverage to employees, although the physician's family is usually covered. The survey found there was little interest in a managed care program although there was a more positive feeling toward restricting the choice of hospitals over restricting the choice of physicians.

Blue Shield representatives discussed the experience of the plan over the past year. Experience in employee code 414, the Low Option, was very good, while experience in employee code 835 was not satisfactory. However, because of the experience in the Low Option and the fact that KMA's rates are based solely on its own experience, it was reported that the current rates for both the High and Low Options would remain the same for 1992. In an effort to increase participation in the plan, Blue Shield had suggested that KMA also offer an Option 2000 program, which shadowed the current plan in terms of benefits. The Option 2000 plan would limit individuals' choice of hospitals and would require medical underwriting, but would offer substantially lower rates than currently available.

It was the consensus of the Committee to recommend to the KMA Board of Trustees that the current High and Low Option plans be maintained and that KMA offer the two new Option 2000 plans as outlined above. That recommendation was adopted by the Board.

Plans were also developed for the KMA Insurance Agency to work with Blue Cross and Blue Shield career staff to develop an aggressive marketing plan in an effort to enlarge enrollment in the program. We also learned that the Agency had found several physicians who were enrolled in the KMA group but had dropped their membership in the Association. Letters were sent to them advising that in order to keep the coverage they would need to reinstate their membership and, to date, all but two physicians have done so.

We are hopeful the expansion of coverage options and a more aggressive marketing effort will bring more physicians, families, and staff into our plan, thereby broadening the pool of insured and moderating the effects of plan utilization.

Electronic Billing — The Committee discussed the concerns voiced today over the administrative costs of health care. Some have estimated that as much as 25% of the cost of health care is attributable to administration. In the past two years, Medicare has provided "incentives" to bill electronically (faster payment) and "disincentives" (slower payment) to those submitting paper claims. This has caused great concern among small, rural practices because of the cost of automation and the anxiety and sometimes frustration that occur in the transition to electronic claims submission. However, the Committee believes that both government and private carriers will continue to move toward electronic claims processing and that it will be in the physician's best interest to become familiar with this concept.

The Committee met with representatives of organizations offering electronic information systems which offer services from the most simple electronic claims submission to the most sophisticated electronic practice management systems. The Committee, through KMA staff, has also facilitated meetings between large carriers which have embraced electronic claims and leaders of the Kentucky Medical Group Management Association. The end result was the feeling that electronic claims submission and payment is becoming more widely used and that KMA should help educate physicians about the concept without endorsing any single vendor or product.

As a result, KMA is coordinating a special seminar on electronic claims during the KMA Annual Meeting on Wednesday, September 16, 1992. The free program will be open to both physicians and

their office staff and is designed to provide information on the likely future plans of Medicare, Medicaid, and other major carriers regarding electronic claims, as well as discuss some areas to be mindful of when considering automated information systems. The Committee is hopeful many members will take advantage of this timely educational opportunity.

I, as Chairman, appreciate the participation and contributions of the members of the Committee. These individuals work very hard on issues with far-reaching implications for all Kentucky physicians. I also appreciate the continuing cooperation and communication we've received from Kentucky Blue Cross and Blue Shield and the Kentucky Department of Personnel.

Donald R. Neel, MD
Chairman

Report of the Committee on Claims and Utilization Review

This year has again shown little solicited activity on the part of the Claims and Utilization Review Committee. As previously reported, in recent years the proliferation of managed care plans and the extensive profiles developed by governmental agencies have made fee review obsolete.

Quality of care issues arise episodically but these, too, are primarily resolved through previous contractual arrangements between the major policyholder and the carrier. Review activity at the district level is essentially sparse, with the exception of a few districts.

At the national level, the propriety of fee review remains equivocal. For some years, the peer review system has avoided review and comment on specific fees because of concerns related to the Federal Trade Commission (FTC). This year, KMA did join with the American Medical Association and other medical societies to request that fee and grievance review should be allowed by the FTC. This took the form of joining in an informal petition with other medical organizations and directing a letter to the FTC. The outcome of this situation is as yet unclear.

On a related matter, representatives of the Committee are currently holding discussions with representatives of the Cabinet for Human Resources (CHR) concerning legislation that regulates utilization review companies. In 1990, KMA supported state legislation that would require utilization review companies to register with the state and to meet minimum requirements of availability of personnel for weekend hospital admissions, availability of physician peer reviewers, and others. There is a current question as to whether or not these criteria apply to KMA's peer review system. Further analysis of the situation is taking place by both the Cabinet and legal counsel for KMA.

As these matters become resolved and new directions emerge, the Committee hopes to increase its activities.

K. Thomas Reichard, MD
Chairman

Report of the PRO Advisory Committee

The PRO Advisory Committee has continued to act on behalf of the Association this year by meeting with representatives of the professional review organization (PRO), formally and informally, to ascertain new developments in the PRO program and to represent member concerns with PRO activities.

Sentinel Medical Review Organization has changed its name to the Kentucky Medical Review Organization for operations in this state. PRO operations in Indiana are now conducted by the Indiana Medical Review Organization. Both organizations are subsidiary to the parent company, Sentinel. Ostensibly, this name change occurred to avoid confusion between the two organizations by the Health Care Financing Administration (HCFA).

A number of changes have occurred in the review process because of contract revisions. The KMRO (Sentinel) contract had been in question with HCFA, and the contract's termination was possible at the beginning of the Associational year. However, it seems that the contract was extended from November through June 1992, and negotiations are currently underway to extend the contract further, to June 30, 1993.

In addition to performance factors, the PRO will be required to operate on a "fee-for-service" basis. The contractor must perform routine tasks for which it is paid on a monthly basis. Additional tasks may be imposed without additional compensation, but payment is not based specifically on the number of cases reviewed. Instead, the PRO must complete review of a random sample of cases, review claims relating to specific procedures, and intensify review of individual physicians in hospitals.

KMRO has employed a new Medical Director, Harry Cowherd, MD. The Committee was gratified to learn of this appointment and looks forward to working with Doctor Cowherd.

The PRO has held a series of regional meetings this year to serve as educational opportunities for physicians. Essentially, these meetings will address quality issues, which will include:

- Proper documentation of patient condition and care
- Physician response to clinical findings
- Proper validation for surgical intervention
- Facility response to physician orders
- Proper discharge planning
- Concerns relating to premature discharge
- Need to appropriately respond to PRO notices

The Committee was also advised that the PRO will seek to improve liaison with the Board of Medical Licensure in those instances where physician behavior appears to warrant review by that agency. In the event that physicians are referred to the Licensure Board, the Board's standard routine of due process will begin. In such an event, the Board would likely initiate a separate investigation, as PRO clinical information cannot be released.

Overall funding of the PRO program was reduced this year, with the result that PRO activities have eventually been reduced. While the Committee continues to receive notice of complaints and dissatisfaction by individual members, the volume of these contacts is minimal. Interruptions in the PRO process relating to contract negotiations have doubtlessly caused the PRO delays in review completion. The outcome of the entire PRO program and the current contractor's involvement is not certain.

The Committee also became aware of some tentative plans by HCFA to develop physician advisory panels, both to the PRO and to the carrier or fiscal intermediary. As of this time, these plans have not fully developed, but are seen as a positive step to provide for physician input into the Medicare program.

The Committee continues to closely observe these activities and to represent the Association to the PRO.

James M. Bowles, MD
Chairman

END OF CONSENT CALENDAR ITEMS

Report of the Committee to Investigate Changing Trends in Medicine

The Committee to Investigate Changing Trends in Medicine met on February 27 and April 23, 1992.

The charge to the Committee is to study and report on evolving delivery and payment mechanisms; to study and report on demographic trends affecting medical practice; to study and report on ethical questions regarding financial considerations versus quality of life; to investigate trends in cost containment activities; and to determine, to the extent feasible, the role of organized medicine in this changing environment.

Some of the issues discussed and reported on by the Committee in the past are the growth of nontraditional payment systems; various cost containment issues; the future physician population; the nursing shortage; physician advertising; the changing demographics of Kentucky; our aging society; medical school demographics; health care rationing; AMA's Health Access America project; rural health care; and managed care systems.

The past year has been a period of significant change for medicine and, before the year is out, we may see even more turmoil in Kentucky. There are 40 proposals to restructure the nation's health delivery and payment system now pending in Congress. Governor Jones' Task Force on Access and Affordability has held 15 town forums across the state and developed its recommendations to the Governor's Commission on Health Care Reform. By the time the House of Delegates meets, we will have more information on what the Commission will propose during the special session of the Kentucky General Assembly later this fall. The Task Force made a number of recommendations, many of which, if enacted, will increase access to care and maintain quality. However, the Task Force offered no suggestions as to how to fund those recommendations other than through a "fair, broad-based, societal tax." KMA supports that concept.

But, these are difficult times. The competitive approach to health care has shifted costs from government to the private sector. The private sector is shifting the cost to individuals. Hospitals are in a "medical arms race" and money once spent to improve patient care is going to advertising firms and to buy time on commercial broadcasting stations. Insurance companies are telling patients that if they go to the Emergency Room but aren't admitted, they must pay half the cost, while hospitals advertise the dangers of mistaking a heart attack for indigestion and encourage people to come to the Emergency Room.

People, understandably, are confused, frustrated, and frightened. Legislators are trying to provide more services with fewer dollars. Competition between physicians is increasing and the distinction between hospital and physician services is less clear.

"The Future of Healthcare: Physicians and Hospital Relationships" — It was within this background that the Committee heard a report on "The Future of Healthcare: Physician and Hospital Relationships." This report is the third in a continuing series of studies conducted by Arthur Andersen and Company and the American College of Healthcare Executives. This report was presented to the KMIC Board of Directors and the KMA Board of Trustees in December.

Diane Cornwell, a partner in the Arthur Andersen Company, and Greg Greenwood, manager of the Arthur Andersen Company, presented the report to the Committee.

Ms Cornwell serves as one of the National Directors of the Health Care Industry Team at Arthur Andersen and participated on the Advisory Committee that created this study.

Overview — The report provides an assessment of the future of physician/hospital relationship in the United States based on the predictions of 2,600 healthcare professionals (1,100 hospital executives; 1,200 physicians; 200 hospital board chairmen; and 100 buyers) about the major developments now under way in the healthcare field.

With the evolution taking place in the delivery of and payment for care, and particularly in the reimbursement of physicians, this study was undertaken to help physicians and hospitals better understand the challenges and opportunities each faces in the next 5 years.

Under the current system, costs continue to rise, as does the public's outcry against them. The federal budget deficit continues to worsen, and the challenge of balancing healthcare expenditures with other vital areas of need becomes even more difficult. An increasing number of Americans without insurance are left without access to the system and, at the same time, the charity burdens on providers are increasing.

Many Americans have come to believe the system is not functioning well and that change is needed. Reform proposals, including those from healthcare provider organizations, are surfacing, but none is being embraced broadly because each requires new expenditures or the giving up of some part of the system.

Over 2,600 healthcare professionals that participated in the study predicted that over the next 5 years:

- healthcare spending, as reflected by the GNP, will continue to escalate;
- a universal health insurance program will not be put in place, although support for one is building;
- managed care will become more prevalent in the marketplace;
- payors will continue to restrain provider rate increases and will attempt to make other cost-saving changes, many of which will be accepted by consumers;
- hospitals will continue to close;
- attention to quality and measurement of value received for payment will increase; and
- providers will be required to release more information to payors and the public.

Differences exist between the predictions of the buyers of care (legislators; regulators; and insurance company, managed care, business coalition, union, and corporate benefits executives) and the major providers (physicians, hospital executives, and hospital board chairmen). Among other issues, the buyers forecast a faster rate of spending, less likelihood of a universal health insurance program or other measures to address the issues of the unemployed and long-term care, and greater likelihood that payments will be linked to the outcomes of care. These differences are critical, according to the study, because it will be the cost issues that drive most of the system changes that are coming.

Physician views differ in many cases from those of hospital participants. Board chairmen hold many views that differ from those of hospital chief executive officers (CEOs), indicating a need for these key leaders to discuss the issues, arrive at a common vision of the future healthcare system, and to share a commitment to the future role of their organizations.

Of the participants in this study, two-thirds of the CEOs and board chairmen describe current physician/hospital relationships as excellent or very good, but only half of the physicians think so. Many more physicians report the relationship to be only fair or poor. These differences in perception will be critical as physicians and hospitals work to develop closer relationships.

Healthcare Share of GNP to Keep Rising — The vast majority

of study respondents expect healthcare's share of the GNP to rise from 11.1% in 1988 to 13% by 1996. It reached 12% in 1990. Buyer panelists and board chairmen predict even greater increases, seeing healthcare's share increasing to 13.5% and 14%, respectively, of the GNP by 1996.

Panelists do not expect much of a shift in spending across various healthcare provider categories. The greatest prediction for change is reflected in the panelists' forecast that the nursing home share will rise from 8% in 1988 to 10% of total 1996 health spending, reflecting the continuous aging of the population.

Expectations of Universal Health Insurance Increasing — Thirty-five percent of the combined panelists felt a universal or national health insurance program will be instituted for all persons by 1996. If universal health insurance is to begin to take shape, panelists expect the movement toward it over the next 5 years to be gradual, with only our society's most vulnerable members being granted new benefits. The panelists believe a program is likely to be instituted for children and noninsured unemployed, but not for long-term care.

Future Delivery System — Panelists were split regarding a possible reorientation of the healthcare system by 1996. When asked to express their views on the likelihood that the healthcare system's general orientation would be redirected by 1996 from curative to preventive services, 41% responded to preventive services; 42% responded to curative services; and 17% had no opinion.

The Shift From Inpatient to Outpatient Continues — The panelists expect the number of inpatient hospital admissions per 1,000 population and the average length of stay to continue to decline. Panelists also predict that as a result of new payment incentives, technological advances, and other developments, the trend for hospitals to obtain more of their patient care revenues through outpatient services will continue to grow.

Limits on Access to Technology to be Rejected — Strong majorities expect payors and consumers to agree on the use of more home care services in place of inpatient services, shorter hospital lengths of stay, and greater use of physician extenders (nurse practitioners and physician assistants). The greatest disparity between payors and consumers is expected to relate to payor attempts to limit the use of advanced technology.

There is not expected to be any sweeping reform, with changes being incremental — employer mandates, tax policy, insurance reform, and entitlement changes.

Managed Care Growth to Continue — Panelists predict that managed care plans will continue to grow.

More Hospitals to Close — The study participants expect that hospital closures will continue at rates similar to those experienced in recent years, with 440 hospitals closing between the years 1991 and 1996.

Disclosure of Information to be Required; Hospitals Reluctant — An overwhelming majority of panelists predict that by 1996 hospitals will be required to disclose certain types of patient care and operational information either to the government or to the Joint Commission on Accreditation of Healthcare Organizations. Most predict that hospitals will not disclose this type of information voluntarily.

Impact of the Data Bank Questioned — A majority of study participants believe defensive medicine will increase, and expect the Data Bank to have no effect on the amount of litigation between physicians and hospitals or on the amount of litigation between physicians and patients.

Rising Costs to Affect all Parties — Government at all levels will feel pressure as deficits persist and the numbers of uninsured and underinsured rise. The federal government will continue to

shift more of the burden of healthcare costs to the states and the private sector, and it will place increasing emphasis on provider payment reductions and on decreases in benefits to recipients.

Employers, to be competitive on a local basis, will have to scrutinize and cut costs and struggle to balance what they can afford to provide in benefits with what employees expect. They will also be required in 1993 to report retiree health benefit obligations in their financial statements.

In response, more employers may consider trimming or eliminating health benefits for employees, now and after their retirement. Such moves would only serve to make government attempts to protect those without adequate coverage more difficult. Organized labor will continue to call for a national health program and the business sector may add its voice to that call.

For consumers, citizens with coverage will continue to pay an increasing share of healthcare costs out of their own pockets. An increasing number may opt to forego coverage rather than pay for expensive private coverage. Others will turn to managed care plans.

The issue that concerns older citizens the most — financial disaster due to a long-term care experience — will not be alleviated in the next five years by an entitlement program. There will be a significant rise in tensions between generations as older Americans desire more governmental spending and protection and younger workers resist contributing more tax dollars and out-of-pocket expenditures.

Providers can expect that the central focus for cost savings by payors will continue to be on decelerating their payment increases. The new cost control emphasis for the 1990s will be hospital outpatient care and physician services, both inpatient and outpatient, with particular emphasis on physician payments coming via Medicare physician payment reforms and managed care.

Competition for services will strain the relationships between physicians and hospitals and among physicians as technology advancements blur the traditional lines across clinical specialties.

Conflicting Policies Must Be Addressed — Providers will be caught in the middle of the conflicting interests of various governmental agencies and between the payors' desire to constrain the system and the public's desire to expand access.

Some of the conflicting policies that must be addressed are:

- Anti-trust problems
- Fraud & abuse rules
- Tax exempt status
- Lack of Tort Reform

Ethical Dilemmas to Mount — an increasing number of ethical dilemmas for healthcare providers will be driven by declining resources, increasing patient acuity; the rapid deployment of new, but expensive, medical technologies; and the continued burden of medical liability costs.

The Impact of Physician Payment and Practice Changes — While constraints on rate increases to hospitals will continue, the new area of payor emphasis will be physician payments. There are four components:

- The resource-based relative value scale (RBRVS) attempts to make payments for various medical services more equitable based on the total resources consumed by the physician in preparing for and delivering a particular service.
- Volume performance standards (VPS) establish annual increases in service volumes that are recognized for payment by the federal government.
- A limit on balance billing restricts the amount nonparticipating physicians can bill patients over and above what Medicare pays.
- Effectiveness research aims to develop guidelines, standards,

measures, and review criteria to be used in reducing the incidence of unnecessary and inappropriate care.

Significant Effects of Physician Payment Reform Predicted — In response to payment system reform, physicians believe they will be more cognizant of cost-effective approaches to care, that medical group practices will grow, and that the volume of invasive and high-technology procedures will grow in response to decreases in payment per procedure. They are not inclined to believe that communications with patients concerning diagnoses and treatment will increase over present levels and are concerned that relationships among physicians will be adversely affected by the reforms.

Hospital CEOs expect that physician/hospital relationships are much more likely to be hindered by physician payment reform.

Private Payors to Adopt RBRVS Fee Schedules — Virtually all respondents (98%) feel it is likely, and 46% of them believe it is very likely, that private payors also will adopt the Medicare physician fee schedule, or some modification of it, by 1996.

Quality Indicators and Outcome Measures to be Used — Seventy-four percent of the panelists predict the establishment of generally accepted patient care outcome and quality indicators by 1996.

Impact of Practice Standards Uncertain — Most of the panelists expect the use of practice standards to lead to decreased payments to physicians. No strong consensus is shown among the combined panelists regarding the effects on the cost of care, the amount of care provided, the quality of that care, or the practice of defensive medicine. The physicians, however, believe that practice standards will increase the practice of defensive medicine and the cost of healthcare.

Mandatory Physician Assignment for Medicare and Medicaid — With regard to the future likelihood of assignment for Medicaid, most participants predict it will be mandated, either by the states or the federal government.

More and Larger Group Practices on the Way — Group practices will continue to grow. The panelists predict that 40% of MDs will be in a group practice by 1996, most single specialty, partly because they want more free time.

A large majority of the panelists predict that there will be a rapid move for private carriers to adopt Medicare fee schedules.

Physicians will Increase Office Practice Efficiency — Physician respondents are in strong agreement that physicians will increase their contracts with managed care organizations, their use of physician extenders, and their likelihood of charging for services now provided for free. In addition, their desire for practice support from the hospital will increase. Physicians also expect that they will increase the scope of practice performed in their offices and increase the hours the office is open but decrease the time they spend with each patient.

Implications of These Findings — Physicians feel they are likely going to be needing additional management support and skills and feel that services to help them manage their income, including reimbursement and the improvement of their billing and collection activities, will be important to them in 1996. Physicians will play more of an advisory role in terms of options available to their patients.

Panelists expect more economic credentialing of MDs. Most hospitals are already tracking this closely now.

Physicians will have to do more to demonstrate their value to the community.

Strategies for the Future — According to the report, physicians must be knowledgeable of the policy and payment system changes that are under way, including their causes and their likely effects.

Physicians must select the mode of practice that best meets

their personal, professional, and economic needs, given the demands of the local marketplace.

Physicians must plan for leadership roles.

Physicians must determine the level of practice productivity that will be required to be competitive.

Physicians must define their role in the growth of managed care.

Physicians must improve their hospital relationships.

Physicians must strengthen their commitment to the measurement and improvement of patient care quality and be prepared to disclose information about quality to the payors.

What Can KMA Do? — KMA will continue to sponsor various practice management workshops and will encourage second-year residents to attend the How to Get Started in Medical Practice seminar sponsored each spring.

KMA should also encourage continuing education for physicians' office staff and work with the Kentucky Medical Group Management Association, the Kentucky Chapter, American Association of Medical Assistants, and other appropriate groups in this area.

It was also suggested that KMA's proposed recommendations to the Health Costs Commission be shared with the Committee and that some type of mechanism, fact sheet, or pamphlet be made available to the membership with documented data of ongoing programs, indigent care, etc. This material could be discussed at hospital medical staff meetings and could also be made available to other associations and organizations for distribution to their employees. Efforts are underway to implement this activity.

Physicians should take a leadership role in advising the general public, at every opportunity, of the benefits of the current delivery and payment system. Any changes in the US delivery system should occur incrementally, and those changes should be assessed on an ongoing basis.

Physicians need to understand that the best form of public relations is done on a one-on-one, physician/patient basis.

The Committee also suggested that KMA consider the feasibility of legislative support for requiring that advance directives be made by everyone in Kentucky over a certain age, eg, 40 years.

Practice Parameters — The Committee also discussed the evolution of practice parameters. Practice parameters are being discussed and developed rapidly at the national specialty level and have the support of KMA and the AMA as a way to insure quality of care as well as serve as a benchmark for appropriate care in professional liability cases.

According to the American Medical Association *Directory of Practice Parameters*, the eight steps detailed below present a strategy for incorporating practice parameters into quality assessment, quality assurance, and quality improvement programs.

Step 1: Issue Identification — The first step in implementing practice parameters into quality related activities involves the identification of specific clinical areas of interest. The areas of interest may come from recommendations or concerns of physicians or other health care professionals; quality assessment; quality assurance or quality improvement activities; risk management programs; or from recommendations of the Joint Commission on Accreditation of Healthcare Organizations or other licensing, regulatory or accrediting activities. When appropriate, quality programs may wish to establish working groups or small task forces of physicians and other health professionals to examine specific topic areas.

Step 2: Issue Refinement — The second step in the process is to refine the specific clinical issues and to determine what issues would best meet their objectives.

Step 3: Identification of Relevant Practice Parameters — The

third step in the process is to identify practice parameters that are relevant to the issues of interest. *The Directory of Practice Parameters*, developed by national medical specialty societies and other physician organizations, lists over 1300 practice parameters.

In addition, the *Practice Parameters Update* is a quarterly publication that lists practice parameters completed in the last quarter, revisions to existing practice parameters, and practice parameters withdrawn by their sponsors.

Practice parameters themselves suggest clinical issues that can be addressed. The publication of new practice parameters by physician organizations may suggest areas of medical practice in the hospital which may require further study.

Once identified, relevant practice parameters can be collected and evaluated to provide information for further analysis of the specific issues of interest.

Step 4: Evaluation of Practice Parameters — Once the practice parameters that refer to the clinical area of interest are identified, the practice parameters can be collected and evaluated.

Step 5: Selection and Modification of Practice Parameters — The recommendations in the practice parameters may be suitable for use as written or may need to be modified in light of the experiences of local physicians and other health care professionals. The processes of selecting, evaluating, and modifying relevant practice parameters should yield the practice parameters that are most relevant to the issues to be reviewed. The practice parameters should also be disseminated to the physicians who will be reviewed. This process provides multiple opportunities for physician input.

Thorough peer review and feedback of findings are critical for physicians to adopt recommendations and modify medical practice. Practice parameters are more likely to be accepted by physicians when developed by relevant physician organizations and reviewed, adapted, and endorsed by local physicians. Further modifications to the practice parameters may be necessary to form a consensus on appropriate medical practice.

Step 6: Implementation of Practice Parameters/Assessment of Practice — The recommendations of specific practice parameters, as modified by local physicians and other health care professionals, need to be implemented with appropriate support to ensure the practice parameters are appropriately disseminated, evaluated, and adopted. The modified practice parameters should be evaluated and endorsed by relevant physician leaders who can encourage consensus about the value of practice parameters in improving the quality of medical care.

A data collection system may also be needed to provide information on practice patterns. Data collection may also help clinicians to evaluate their performance in relation to the practice parameters. Following the outcomes of care over time permits physicians to evaluate the appropriateness of care and effectiveness of the practice parameters.

Step 7: Evaluation and Feedback — Quality assessment, quality assurance, and quality improvement results should be used to improve practitioners' performance and thus improve the quality of care. To the degree possible, quality programs should be structured to recognize care of high quality, as well as correcting instances of deficient practice. Practitioners reviewed should systematically receive results of the review and should be assisted in improving their knowledge and in modifying their practice patterns where indicated. Clinicians can evaluate their performance in relation to the modified practice parameters, which can help to determine appropriate medical management, as well as suggesting what additional steps are required to pursue any potential quality of care issues. Practice parameters, which have been endorsed by profes-

sionals whose performance is monitored, allow for a physician-directed activity to help modify practice patterns when necessary. Feedback mechanisms should be established to channel information regarding the effectiveness of the recommendations, areas identified as needing improvement, as well as providing continued evaluation of practice patterns which can facilitate compliance with the recommendations.

Step 8: Periodic Review of Practice Parameter Recommendations — The quality assessment, quality assurance, and quality improvement process itself should be subject to continued evaluation and modification as needed. The recommendations of the practice parameters and the task force will need to be periodically reviewed and modified as needed to maintain their relevance to current practice. As medical knowledge advances and local conditions change, modifications to the recommendations should occur.

Physicians and other health care professionals can benefit from the evaluation and implementation of practice parameters. Properly developed and implemented, practice parameters present a promising strategy to define appropriate medical care and provide a rational foundation for improving the quality of medical care. Practice parameters can be an integral component of any quality assessment, quality assurance, or quality improvement program by providing physician-developed recommendations to improve the quality of patient care. The Committee reviewed videotapes encompassing the information presented in this report. Copies of the tapes are available on loan from the Headquarters Office on request.

After viewing the tapes, the Committee discussed its concern that medical care would become "cookbook medicine" due to the diversity of medical practice. Other concerns were the dissemination of practice parameters information to physicians without their being adopted as standards of care or being used selectively by third parties. However, the parameters will provide guidelines to the courts regarding appropriateness of care. If a physician chooses not to follow the parameters, he or she should document information for making that decision appropriately and thoroughly in the patient's chart.

I appreciate having the opportunity of serving as Chairman of this Committee and appreciate the support and participation of the Committee members.

Robert R. Goodin, MD
Chairman

RECOMMENDATIONS:

1. The Committee to Investigate Changing Trends in Medicine recommends that KMA should encourage continuing education for physicians' office staffs and work with the Kentucky Medical Group Management Association; the Kentucky Chapter, American Association of Medical Assistants; and other appropriate groups in this area.
2. The Committee to Investigate Changing Trends in Medicine recommends that physicians should take a leadership role in advising the general public, at every opportunity, of the benefits of the current delivery and payment system. Any changes in the US delivery system should occur incrementally and those changes should be assessed on an ongoing basis.
3. The Committee to Investigate Changing Trends in Medicine recommends that physicians need to understand that the best form of public relations is done on a one-on-one physician/patient basis.
4. The Committee to Investigate Changing Trends in Medicine rec-

ommends that KMA consider the feasibility of legislative support for requiring that advance directives be made by everyone in Kentucky over a certain age, eg, 40 years.

Recommendations, Reference Committee 4:

Reference committee No. 4 would like to commend the Committee to Investigate Changing Trends in Medicine for its excellent and thorough efforts on the issues presented in its report. The Reference Committee recommends that Report No. 29 be filed, and that its Recommendations be adopted.

RESOLUTION H

Medication Labeling

Floyd County Medical Society

RESOLVED, that the Kentucky Medical Association work with appropriate agencies to require all patient medications to have labels which contain a clear statement of dosage, administration, and patient.

Recommendations, Reference Committee 4:

Reference Committee No. 4 next reviewed Resolution H, Medication Labeling, introduced by the Floyd County Medical Society. The Reference Committee felt that Resolution H seemed to duplicate existing law and since no one from Floyd County was present to speak on the intent of the Resolution, Reference Committee No. 4 recommends that Resolution H be rejected.

RESOLUTION N

Education of Students on the Hazards of Ultraviolet Radiation (Tanning Rays)

Northern Kentucky Medical Society, Inc.

WHEREAS, the adverse effects of ultraviolet radiation (whether it originates from a tanning parlor or the sun) include: (1) skin cancer formation; (2) premature aging of the skin; (3) cataract formation and other eye damage including blindness; (4) impairment of the immune system; (5) photosensitizing reaction with various drugs; (6) initiation and aggravation of certain diseases such as lupus erythematosus, porphyrias, herpes infection, etc; (7) burns; and (8) DEATH; and

WHEREAS, at least one of every six children is destined to develop a skin cancer during their lifetime; and

WHEREAS, there are 600,000 plus new cases of skin cancer each year and most of these skin cancers are preventable; and

WHEREAS, people receive 80% of their dangerous lifetime exposure to ultraviolet radiation (tanning rays) before the age of 20; and

WHEREAS, it is important to educate students before the damage has occurred; and

WHEREAS, teachers are in an excellent position to educate their students about the hazards of ultraviolet radiation; and

WHEREAS, the Cincinnati Dermatological Society, the Ohio State Medical Association and Auxiliary, the Ohio Dermatological Association, the Midwestern Congress of Dermatological Societies, the American Academy of Dermatology, the American Medical Association, and numerous other medical organizations have adopted Resolutions to educate the public about the hazards of tanning and to develop tanning parlor legislation; and

WHEREAS, numerous cities and/or states have passed or will pass tanning parlor laws; and

WHEREAS, the Ohio Dermatological Association, the Ohio State Medical Association, and the Ohio State Board of Education have all adopted Resolutions to work with each other to introduce

into the school curriculum information about the hazards of tanning and are in the process of doing so; and

WHEREAS, the American Medical Association House of Delegates has adopted a similar Resolution to work with the United States Department of Education to teach about the hazards of tanning; now therefore be it

RESOLVED, that the Kentucky Medical Association work with the Kentucky State Board of Education to include in the curriculum appropriate information for teachers to educate their students about the hazards of ultraviolet radiation and tanning parlors.

Recommendations, Reference Committee 4:

Reference Committee No. 4 next considered Resolution N, Education of Students on the Hazards of Ultraviolet Radiation, introduced by the Northern Kentucky Medical Society, Inc. The Reference Committee recommends that Resolution N be adopted.

Mr Speaker, Reference Committee No. 4 recommends the adoption of the report of Reference Committee No. 4 as a whole.

I would sincerely like to thank the other members of the Committee: Harry W. Carlross, MD, Paducah; David Douglas, MD, London; Daniel E. Kenady, Sr, MD, Lexington; and John M. Patterson, MD, Frankfort. I would also like to thank Martha Coombs for her assistance in the preparation of this report.

Respectfully submitted,

REFERENCE COMMITTEE NO. 4

K. Thomas Reichard, MD, Louisville, Chairman

Harry W. Carlross, MD, Paducah

David W. Douglas, MD, London

Daniel E. Kenady, Sr, MD, Lexington

John M. Patterson, MD, Frankfort

Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional action taken by the house is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE NO. 5

Jane R. Bramham, MD, Bowling Green, Chair

30. Report of the Committee on Maternal and Child Health

31. Report of the Technical Advisory Committee on Physician Services (Title XIX)

32. Report of the Committee on Community and Rural Health

33. Report of the Committee on School Health, Physical Education, and Medical Aspects of Sports

Resolution F — School Health Clinics

(Floyd County Medical Society)

Resolution G — Family Violence

(Floyd County Medical Society)

Resolution Q — Tax-Free Income for Services to Medicare/Medicaid Patients

(J. Gregory Cooper, MD, Chairman, YPS)

Resolution S — Family Violence

(Board of Trustees)

ITEMS FOR CONSENT

Reference Committee No. 5 reviewed the following items and recommends they be filed, by consent of the House, without discussion:

31. Report of the Technical Advisory Committee on Physician Services (Title XIX) — filed

32. Report of the Committee on Community and Rural, Health — filed

33. Report of the Committee on School Health, Physical Education, and Medical Aspects of Sports — filed

Reference Committee No. 5 would like to express its appreciation to the chairmen and members of these committees for their time and effort in dealing with the issues discussed in the reports.

Mr Speaker, Reference Committee No. 5 recommends adoption of the Consent Calendar as a whole.

Report of the Technical Advisory Committee on Physician Services (Title XIX)

The Technical Advisory Committee on Physician Services (Title XIX), "Physician TAC," is one of 11 members of the Advisory Council for Medical Assistance. As a member of the Advisory Council, the Physician TAC meets on a quarterly basis in order to discuss and evaluate problems and concerns faced by physicians when dealing with the Kentucky Medical Assistance Program (Medicaid). If the physician TAC determines that the issues discussed require action, the Physician TAC, through its chairman, presents these issues to the Advisory Council in the form of a written report and makes a formal recommendation for action to be taken.

Pursuant to a formal opinion from the Cabinet for Human Resources dated November 12, 1991, all Technical Advisory Committees are now subject to the provisions of the open meetings laws, KRS 61.805-61.850. These laws stipulate that meetings shall be open to the public and shall be scheduled to allow effective public observation and news media coverage.

In the fall of 1991, the Physician TAC closely monitored the status of the implementation of House Bill 21, the Medicaid provider tax. During the first year of implementation, the Physician TAC had received favorable responses from physicians resulting from the implementation of increased reimbursements.

In the spring of 1992, the Physician TAC reviewed the Health Care Financing Administration's (HCFA) final rule abolishing the state's ability to apply the physician's tax dollars to the state's matching funds after July 1993. Representatives of the Kentucky Medical Association attended meetings in Washington where HCFA explained its final regulations denouncing Kentucky's provider tax system as set forth in HB 21. The Physician TAC will actively monitor the implementation of any new provider tax bills introduced to replace the existing system.

The Physician TAC received a request to investigate the problems associated with current CPT coding which differentiates between inpatient/outpatient payment levels for procedures which cannot be safely performed on an outpatient basis. The Physician TAC began working with Roy Butler, Commissioner, and Janie Miller, Deputy Commissioner, Department for Medicaid Services, on these issues.

On March 4, 1992, the Physician TAC filed its report with the Advisory Council. The report stated that: In an effort to control costs. Medicaid reimburses outpatient procedures at a higher rate than inpatient procedures. Although understandable in most instances, the degree of postoperative care required in certain cases mandates hospital admission. Therefore, according to the specialists involved, certain surgeries cannot be performed on an outpatient basis under the proper standards of care. Because it is irrational to discount such a procedure in order to cut costs, the Physician TAC requested

that the reimbursement for the inpatient procedure should be set at the higher outpatient rate.

Additionally, it was brought to the attention of the Physician TAC that Medicaid is reimbursing physicians for certain surgical procedures at rates which have little or no correlation with the degrees of difficulty set forth under Medicare's Resource Based Relative Value Scale (RBRVS). In certain procedures, there is a huge discrepancy in payment levels within the RBRVS system and almost no discrepancy in payments under the Medicaid fee schedule.

The Physician TAC was asked to review the patient anti-dumping provisions contained in OBRA 90 with the current KenPAC requirements in order to determine if there is a conflict with federal anti-dumping provisions. The problem arises when the hospitals are staffed by independent emergency room physicians under contract with the hospitals. The federal patient anti-dumping provisions contained in OBRA 90 require emergency room physicians to examine each patient to determine medical condition prior to refusing treatment. If a true emergency exists, the Medicaid department provides reimbursement to both the hospital and the physician. If an emergency does not exist, however, Medicaid will not pay the hospital or physician for the federally mandated screening performed by the physicians. Therefore, any independent physician under contract with a hospital to provide emergency services is not reimbursed for the screening. The Physician TAC is actively working with Medicaid to resolve this conflict. Suggestions include paying a nominal screening fee in the amount of \$25 to \$35. The Physician TAC made three recommendations to the Advisory Council:

1. That the Advisory Council for Medical Assistance ask the Department for Medicaid Services to consult with a board certified specialist to determine if certain procedures can be performed on an outpatient basis under the approved standard of care. If the specialist is in agreement with the Physician TAC, the Physician TAC recommends that the department terminate the discount for inpatient treatment of these procedures and reimburse physicians at the higher outpatient rate.
2. That the Advisory Council for Medical Assistance ask Medicaid to review its determination of reimbursement rates for certain surgical procedures which are in conflict with federal Medicare resource-based relative value units that are based on the degree of difficulty and consider adjusting payment levels to more accurately reflect the time and difficulty of each procedure.
3. That the Advisory Council request that Medicaid study the dilemma of independent physicians under contract with hospitals to provide emergency services. The Physician TAC further recommends that reimbursement be made to physicians for screening KenPAC patients who present at hospital emergency departments for nonemergency procedures.

The Physician TAC is currently negotiating with Medicaid regarding these issues and will report back to the Advisory Council at future meetings. As of this date, Medicaid continues to study all three concerns previously listed and expects to have recommendations in the near future.

The Physician TAC is pleased to announce the addition of two new members to the Department for Medicaid Services Formulary Subcommittee. Upon the recommendation of the Kentucky Medical Association, A. O'tayo Lalude, MD, Louisville, who is also a member of the Physician TAC has been approved as the family physician representative on the Subcommittee, and Nat H. Sandler, MD, Lexington, has been approved as the psychiatrist member.

We will continue working toward our goal of providing a forum in which Kentucky physicians may discuss their suggestions and

ideas in order to provide the best quality medical services to Kentucky's indigents. The Physician TAC wishes to thank Commissioner Butler and Deputy Commissioner Miller for their assistance throughout the year.

Harold L. Bushey, MD
Chairman

Report of the Community and Rural Health Committee

The Community and Rural Health Committee met on one occasion this year. A major topic of discussion for the Committee was domestic/interpersonal violence.

The Committee acknowledged the increased violence in our society, especially in the home. As a result, the Committee decided that since physicians play a major role in recognizing domestic/interpersonal violence, the Kentucky Medical Association should educate physicians in the recognition of spouse abuse, proper communication with the patient, and the proper avenue to take when reporting spouse abuse, since it is mandatory by Kentucky law.

The Committee recommended that a subcommittee be formed to deal with issues of domestic/interpersonal violence and to make proposals to the full Committee to forward to the KMA Board of Trustees and, if appropriate, to the KMA House of Delegates.

The "Blue-Ribbon" Subcommittee on Domestic/Interpersonal Violence, chaired by Baretta R. Casey, MD, met on June 8, 1992. Members included the Honorable Attorney General of Kentucky, Chris Gorman, LLB; Mike Conliffe, JD, Jefferson County Attorney; and other involved individuals. The Subcommittee participants represented a broad base of agencies that work with domestic violence cases on a daily basis, including the Office of the Attorney General; the Office of the Jefferson County Attorney; the Office of the Commonwealth Attorney, Fayette County; the Kentucky Domestic Violence Association; the YWCA Center for Women and Families; and the Department for Social Services, Family Services Program, Adult Protective Services.

The Subcommittee was charged with recommending to the Kentucky Medical Association methods to improve physician education, in order to better deal with the complex problem of domestic/interpersonal violence.

The Subcommittee, through extensive discussion, identified several myths that exist which hinder physicians from taking proper action. Those include:

1. The physician may face a lawsuit for reporting domestic violence.
2. Reporting domestic violence results in a worse situation for the family.
3. Striking a spouse is acceptable.

Representatives of the various agencies on the Subcommittee reported their efforts to deal with domestic violence cases, in order for the Subcommittee to recommend the best possible education program for physicians.

The Subcommittee found there currently exists a critical need for the medical community to recognize domestic violence as a chronic problem and to become more aware of the need for identification and reporting.

Physicians should recognize the law and not simply treat domestic violence as a private family dispute. The attitudes and practices of physicians may determine whether a victim survives the violence and seeks resolution to the problem. Proper instructions to the patients and reporting to appropriate authorities will assist in

stemming the violence in the long run and bring this costly and devastating effect upon American families to an end.

The Subcommittee recommended short- and long-term goals:

Short-Term

- Educate physicians on the problem of domestic violence.
- Instruct physicians on the present laws in Kentucky as they relate to reporting known and suspected domestic violence.
- Educate communities by providing brochures to physician offices, hospitals, and other public places.

Long-Term

- Recommend that medical schools in Kentucky implement courses on diagnosing abused victims. The Committee noted that physicians' treatment and attitude toward abuse victims can make a significant impact upon whether a victim seeks further help and considers filing criminal charges.

The Subcommittee recommends the KMA Committee on Community and Rural Health develop an educational program for Kentucky physicians to increase awareness in recognizing and reporting domestic/interpersonal violence.

Another major topic of discussion was AIDS. The level of awareness of AIDS in the medical community in Kentucky is not as prevalent as in the larger metropolitan areas. The Committee discussed programs to educate physicians to recognize AIDS-related symptoms in their patients, and to be sensitive and knowledgeable on the subject when they encounter an AIDS patient. Kentucky currently has no mandatory CME requirements, but newly licensed physicians coming from out of state are required to complete AIDS/HIV infection education in order to qualify for licensure.

Reginald Finger, MD, Director, Division of Epidemiology, reported that the Health Department is researching reasons for short survivals of AIDS patients in Kentucky. After a patient is diagnosed with AIDS/HIV infection, patient survival averages one year, whereas on the national level, the average is two years. A possible reason is that Kentucky physicians have not had much exposure to AIDS patients compared to physicians in areas of the country where there is a high number of HIV-infected patients, and are not recognizing the symptoms of the disease.

The Health Department, through a recent mailing, requested counties to appoint a facilitator to assist in providing appropriate care for HIV positive or AIDS-infected patients. After two mailings, only 70 of 120 counties responded.

The House of Delegates adopted the Committee's recommendation that called for the development of an advocacy panel to assist HIV positive physicians, recommend career adjustment or counseling, and provide support in dealing with personal and business problems. Temporarily, this Committee will serve as the advocacy panel; however, in the coming year, we will attempt to seek other appropriate individuals to serve on the panel.

The Committee also addressed the House of Delegates recommendation concerning the problem of methicillin resistant *Staphylococcus aureus* infections (MRSA) patients and the reluctance of nursing homes to admit MRSA patients. This issue drew a great deal of discussion from the Committee.

Elderly patients are being transferred to hospitals from nursing homes with either colonization or active infection with MRSA. The Committee noted that requiring MRSA patients to remain in hospitals strictly because of MRSA colonization/infection is an extremely expensive and inappropriate way of treating patients. The Committee on Community and Rural Health recommended that KMA meet with representatives of the Kentucky Association of Health Care Facilities and the Kentucky Hospital Association to seek resolution to the issue of hospitalizing or denying nursing home admission for

MRSA-diagnosed patients. KMA met with representatives from the KAHCF and KHA. It was suggested that we meet with the Cabinet for Human Resources to determine the best use of the recommendations from the 1991 Task Force "Guidelines for the Control of methicillin resistant *Staphylococcus aureus* infections (MRSA)." There appears to be a lack of education of MRSA patients and unnecessary fear of health care workers about MRSA infection. To address the problem, the KMA asked the KHA and KAHCF to continue to educate their members about MRSA infection and instruct compliance with current MRSA guidelines.

Upon recommendation by Reference Committee No. 5 at the 1991 Annual Meeting, the Committee commended the work of Reginald Finger, MD, and the Department for Health Services for their outstanding work for the children of Kentucky. We heartily join in that praise and point out that Doctor Finger is a valuable resource and contributing member of this Committee.

The Committee discussed the 1991 House of Delegates Resolution BB regarding personal listening devices used by pedestrians, joggers, and bicyclists, which impair and limit their awareness of potential roadway perils. The Committee recommended that the KMA urge individual medical societies to support local ordinances to ban use of personal listening devices which impair an individual's ability to walk, jog, or travel safely on public roads.

We thank the KMA Board of Trustees for being permitted to serve and urge members to refer relevant concerns to the Committee.

Ardis D. Hoven, MD
Chairperson

Report of the Committee on School Health, Physical Education, and Medical Aspects of Sports

The Committee on School Health, Physical Education, and Medical Aspects of Sports met on three occasions during the 1991-92 Association year.

Resolution Q — Health Education and Physical Fitness Testing in Kentucky Schools — was referred to the Committee from the 1991 House of Delegates. The "resolved" portion of Resolution Q reads as follows: "Resolved, that the Kentucky Medical Association take action to encourage uniform health education and physical fitness proficiency testing in all schools." The Committee carefully studied the issue and has temporarily referred the Resolution to Ms Terry Vance of the Department of Education, an ex-officio member of the Committee. Once Ms Vance has completed her research, the Committee will readress the issue and seek to resolve it in the coming year. Members of the Committee agreed that some direction would be needed in defining fitness testing and other components before final recommendations can be proposed.

Resolution S — Use of Steroids and Amino Acids — was referred to the Committee by the 1990 House of Delegates. Resolution S urged the introduction of legislation to require mandatory drug testing for high school students. The Committee recognized the near impossibility of imposing mandated testing for all students due to costs and various legal and constitutional constraints. Committee member J. Michael Ray, MD, in consultation with the University of Kentucky, conducted a year-long survey of high school administrators and students on their attitudes toward mandatory drug testing. Results of that survey are attached to this report.

As a result of the adoption of HB 433 by the 1990 Kentucky

General Assembly (KGA) allowing school children in grades seven and eight to participate in varsity sports, this Committee's 1991 recommendation to the House brought about the passage of HB 750 in the 1992 KGA. HB 750 restricts competition in varsity football, wrestling, and soccer to students who have successfully completed the 8th grade and permits the Department of Education to adopt appropriate regulations. The Committee will work with the Department of Education in accomplishing the aim of this legislation, to protect the health and safety of Kentucky's school children. We commend the Committee on State Legislative Activities for their work in seeing that this important legislation was adopted.

At the request of 1990 Reference Committee No. 5, the Committee on School Health, Physical Education, and Medical Aspects of Sports has produced a booklet entitled "Nutrition Guidelines for the High School Athlete." Special recognition goes to Committee member Michael J. Miller, MD, for his work on this project. The booklet will be distributed to high school athletic team coaches at the 13 Sports Medicine Symposia scheduled for 1992 by the Committee.

The supply of *A Syllabus of Sports Injury Care for the Kentucky High School Coach* presented at the 1990 and 1991 symposia has been depleted. Due to the demand by newly hired coaches for this booklet, the Committee felt a reprinting would be worthwhile if funding could be attained. The Kentucky Department of Education had provided a grant for the initial printing but due to budget shortfalls was unable to honor our request for a second printing. Contact has been made with the Upjohn Company and an agreement is currently being explored whereby funds can be obtained for a second printing.

Discussion with the Kentucky High School Athletic Association member of the Committee brought an agreement that CPR would no longer be required at the Sports Medicine Symposia, but that coaches must be informed that they will continue to need yearly recertification. The *Guidelines* were amended to show this change.

The Committee was successful in 1990 in convincing the Department of Education to also require cheerleader coaches to attend these programs. The 1992 programs will be the first to also be attended by cheerleader coaches. The following dates and sites were set for 1992:

- May 16 — Jenny Wiley State Park/Prestonsburg
- June 6 — Barbourville Community College
- June 6 — University of Louisville
- June 12 — Murray State University
- June 13 — Kings Daughters Medical Center/Ashland
- June 17 — Ramada Inn/Lexington
- June 19 — Trover Clinic/Madisonville
- June 20 — Kentucky Wesleyan College
- June 27 — Hyatt Regency/Lexington
- July 17 — Northern Kentucky University
- Aug 15 — Hyatt Regency/Lexington
- Sept 12 — Holiday Inn North/Lexington

The Committee continues to receive requests from hospitals and schools for approval of their own sports medicine program. The *Guidelines for Sports Medicine Symposia* was prepared several years ago for this purpose and continues to be updated by the Committee for appropriateness.

The Committee received an inquiry this year from the Fayette County Medical Society regarding current rules relating to the use of protective equipment in high school sports. The Committee will undertake this issue as a major project in the coming year and communicate with the National Rules Association, if necessary.

The Committee continues to be extremely busy in seeking to

ensure the health and safety of our school children. We look forward to continuing our work with the Kentucky Department of Education, Kentucky High School Athletic Association, and KMA during the upcoming year.

R. Quin Bailey, MD
Chairman

Study of Drug and Alcohol Use and Attitudes Regarding Substance Abuse Testing in the High School Setting

JAMES MICHAEL RAY, MD

Sponsored by the Kentucky Medical Association

Review

The KMA sponsored study of attitudes of high school students toward drug testing in the high school setting has been completed. The initial survey of high school administrators was presented to you at an earlier date.

A two stage cluster sample was conducted of one history class in each of four randomly selected high schools from four randomly selected KHSAA basketball regions. Our original intention was to survey five schools from each of four regions. The difficulty which arose involved a refusal by some schools to participate after originally agreeing to do so. We then modified the survey to include four schools from the four regions.

A US History class was chosen as the sample base because of the relative homogeneity of the group. High school US History classes are offered in the junior year and except for minor exceptions (repeaters) included junior year students. These history classes are not stratified as to student knowledge level. They are not divided into remedial, normal and advanced as many other high school disciplines (eg: math and English).

The survey involved questions regarding self reported drug and alcohol usage frequencies, as well as questions regarding self reported attitudes toward variations in substance abuse testing at the high school level. The most interesting answers involved the following questions: 9, 10, 11, 13, 15, and 16. In questions 7 through 16 we were attempting to determine what groups the junior students felt should be substance abuse tested and if they felt that it would be effective. In question 9 the students' responses indicated that 48% either strongly agreed or agreed that students involved in extracurricular activities should be tested. This was the highest percentage involved in the group identification. (Question 14 was asked in a different manner and cannot be used.) Question 10 indicated that 59% of the students either strongly agreed or agreed that disciplinary action should be imposed for students who test positive. Question 11 showed that 54% of the students either strongly agreed or agreed that random substance abuse testing would cut down on the abuse of drugs and alcohol. The students' responses to question 13 show that 53% of the students would volunteer for substance abuse testing. This may indicate a need to examine the voluntary drug testing program at Edison High School in Huntington Beach, California. The responses to question 15 show that 58% of the students felt that knowing one could be substance abuse tested would be a deterrent. Lastly, the responses to question 16 indicate that 68% of the students would still participate in extracurricular activities even if required to be substance abuse tested.

The survey is descriptive in nature. Each question should be examined on its own. The data comes from a random sample of Kentucky high school juniors and therefore is representative of the population of Kentucky high school juniors. The results are printed

on the attached survey form. As required by University of Kentucky Institutional Review Board, all students had to complete an assent form and have their parent or legal guardian complete a consent form on their behalf. Again, as required by the IRB these forms will be kept on file at the University of Kentucky Sports Medicine Center.

Thank you for your sponsorship of this survey, we hope that it will assist you in your future decisions.

Grant Money Expenditures

As per University regulations the appropriated funds were deposited in an account under the research department. Funds were utilized for both surveys.

Appropriation \$760.00	
Mileage 1209 miles @ \$.275/mile	332.47
Postage	230.00
Duplicating	120.00
Supplies	62.00
Telephone	27.35
Administrative/Personnel	No cost

	771.82

DO NOT PUT YOUR NAME OR OTHER IDENTIFYING MARKS ON THIS SURVEY

Instructions: Mark the appropriate response.

- How many times have you used alcohol in the past year?
 - ☐ None 95 - 31.5%
 - ☐ Once or Twice 105 - 34.8%
 - ☐ Monthly 57 - 18.9%
 - ☐ Weekly 44 - 14.6%
 - ☐ Daily 1 - .3%
- How many times have you used cocaine/crack in the past year?
 - ☐ None 284 - 94.0%
 - ☐ Once or Twice 13 - 4.3%
 - ☐ Monthly 3 - .9%
 - ☐ Weekly 1 - .3%
 - ☐ Daily 1 - .3%
- How many times have you used Marijuana in the past year?
 - ☐ None 211 - 69.9%
 - ☐ One or Twice 56 - 18.5%
 - ☐ Monthly 14 - 4.6%
 - ☐ Weekly 14 - 4.6%
 - ☐ Daily 6 - 2.0%
- How many times you used Barbiturates/Tranquilizers (downers) in the past year?
 - ☐ None 254 - 84.1%
 - ☐ Once or Twice 83 - 10.9%
 - ☐ Monthly 11 - 3.6%
 - ☐ Weekly 4 - 1.3%
 - ☐ Daily 0 - 0
- How many times have you used Amphetamines (speed) in the past year?
 - ☐ None 237 - 78.5%
 - ☐ Once or Twice 42 - 13.9%
 - ☐ Monthly 15 - 5.0%
 - ☐ Weekly 4 - 1.3%
 - ☐ Daily 4 - 1.3%
- How many times have you used Steroids in the past year?
 - ☐ None 295 - 97.7%
 - ☐ Once or twice 6 - 2.0%

- ☐ Monthly 1 - .3%
 - ☐ Weekly 0 - 0
 - ☐ Daily 0 - 0
- All students at the high school level should be randomly tested for substance abuse.
 - ☐ Strongly Agree 54 - 17.9%
 - ☐ Agree 63 - 20.9%
 - ☐ No Opinion 76 - 25.1%
 - ☐ Disagree 64 - 21.1%
 - ☐ Strongly Disagree 45 - 14.9%
 - Only student-athletics should be randomly tested for substance abuse.
 - ☐ Strongly Agree 18 - 6.0%
 - ☐ Agree 57 - 18.9%
 - ☐ No Opinion 70 - 23.1%
 - ☐ Disagree 110 - 36.4%
 - ☐ Strongly Disagree 47 - 15.5%
 - All students involved in any extra-curricular activity (Sports, Band, Clubs, etc.) should be randomly tested for substance abuse.
 - ☐ Strongly Agree 45 - 14.9%
 - ☐ Agree 100 - 33.1%
 - ☐ No Opinion 63 - 20.9%
 - ☐ Disagree 71 - 23.5%
 - ☐ Strongly Disagree 22 - 7.3%
 - Disciplinary action should be imposed for those who test positive for substance abuse.
 - ☐ Strongly Agree 73 - 24.1%
 - ☐ Agree 107 - 35.4%
 - ☐ No Opinion 68 - 22.5%
 - ☐ Disagree 34 - 11.3%
 - ☐ Strongly Disagree 19 - 6.3%
 - Random substance abuse testing will cut down on abuse of drugs and alcohol.
 - ☐ Strongly Agree 49 - 16.2%
 - ☐ Agree 113 - 37.4%
 - ☐ No Opinion 50 - 16.6%
 - ☐ Disagree 71 - 23.5%
 - ☐ Strongly Disagree 18 - 6.0%
 - Substance abuse testing should be mandatory.
 - ☐ Strongly Agree 35 - 11.6%
 - ☐ Agree 82 - 27.1%
 - ☐ No Opinion 76 - 25.1%
 - ☐ Disagree 73 - 24.1%
 - ☐ Strongly Disagree 32 - 10.6%
 - I would volunteer for substance abuse testing.
 - ☐ Yes 162 - 53.6%
 - ☐ No 64 - 21.2%
 - ☐ I am not sure. 74 - 24.5%
 - Should class officers be tested for substance abuse?
 - ☐ Yes 126 - 41.7%
 - ☐ No 104 - 34.4%
 - ☐ I am not sure. 70 - 23.2%
 - If you knew that you could be drug tested, would this keep you from using drugs and alcohol?
 - ☐ Yes 174 - 57.6%
 - ☐ No 70 - 23.2%
 - ☐ I am not sure. 56 - 18.5%
 - If you were required to be drug tested in order to participate in extracurricular activities (sports, band, clubs), would this keep you from participating in these activities?
 - ☐ Yes 54 - 17.8%

- | | |
|---|-------------|
| <input type="checkbox"/> No | 205 - 67.9% |
| <input type="checkbox"/> I am not sure. | 41 - 13.6% |
| 17. Do you believe that using drugs improves athletic performance? | |
| <input type="checkbox"/> Yes | 14 - 4.6% |
| <input type="checkbox"/> No | 247 - 81.8% |
| <input type="checkbox"/> I am not sure. | 24 - 7.9% |
| 18. Do you believe that using drugs improves performance in the classroom? | |
| <input type="checkbox"/> Yes | 14 - 4.6% |
| <input type="checkbox"/> No | 270 - 89.4% |
| <input type="checkbox"/> I am not sure. | 16 - 5.3% |
| 19. Do you believe that using drugs hurts athletic performance? | |
| <input type="checkbox"/> Yes | 235 - 77.8% |
| <input type="checkbox"/> No | 31 - 10.2% |
| <input type="checkbox"/> I am not sure. | 36 - 12.0% |
| 20. Do you believe that using drugs hurts performance in the classroom? | |
| <input type="checkbox"/> Yes | 250 - 82.8% |
| <input type="checkbox"/> No | 26 - 8.6% |
| <input type="checkbox"/> I am not sure. | 26 - 8.6% |
| 21. Do you believe that drinking alcohol improves athletic performance? | |
| <input type="checkbox"/> Yes | 13 - 4.3% |
| <input type="checkbox"/> No | 277 - 91.7% |
| <input type="checkbox"/> I am not sure. | 12 - 4.0% |
| 22. Do you believe that drinking alcohol improves performance in the classroom? | |
| <input type="checkbox"/> Yes | 11 - 3.6% |
| <input type="checkbox"/> No | 276 - 91.4% |
| <input type="checkbox"/> I am not sure. | 15 - 5.0% |
| 23. Do you believe that drinking alcohol hurts athletic performance? | |
| <input type="checkbox"/> Yes | 239 - 79.1% |
| <input type="checkbox"/> No | 33 - 10.9% |
| <input type="checkbox"/> I am not sure. | 30 - 10.9% |
| 24. Do you believe that drinking alcohol hurts performance in the classroom? | |
| <input type="checkbox"/> Yes | 249 - 82.5% |
| <input type="checkbox"/> No | 30 - 10.0% |
| <input type="checkbox"/> I am not sure. | 23 - 7.6% |
| 25. Do you believe that taking steroids improves athletic performance? | |
| <input type="checkbox"/> Yes | 79 - 26.2% |
| <input type="checkbox"/> No | 158 - 52.3% |
| <input type="checkbox"/> I am not sure. | 65 - 21.5% |
| 26. Do you believe that taking steroids improves performance in the classroom? | |
| <input type="checkbox"/> Yes | 5 - 1.7% |
| <input type="checkbox"/> No | 257 - 85.1% |
| <input type="checkbox"/> I am not sure. | 38 - 12.6% |
| 27. Do you believe that taking steroids hurts athletic performance? | |
| <input type="checkbox"/> Yes | 167 - 55.3% |
| <input type="checkbox"/> No | 58 - 19.2% |
| <input type="checkbox"/> I am not sure. | 75 - 25.0% |
| 28. Do you believe that taking steroids hurts performance in the classroom? | |
| <input type="checkbox"/> Yes | 172 - 57.0% |
| <input type="checkbox"/> No | 52 - 17.2% |
| <input type="checkbox"/> I am not sure. | 76 - 25.2% |

END OF CONSENT CALENDAR ITEMS

Report of the Committee on Maternal and Child Health

The Committee on Maternal and Child Health continues to address the growing shortage of patient access to obstetrical care in Kentucky. Research completed by the Committee this year indicates that only 26 Kentucky family physicians currently deliver babies. The Committee will continue monitoring Kentucky's residency programs to ascertain the number of physicians who will be delivering babies and to encourage residents to enter this training.

Resolution T — Prenatal Visit to Pediatrician or Family Physician — was referred to the Committee from the 1991 House of Delegates. The Committee plans a mailing to all OB/GYNs and family physicians who deliver obstetrical care, stressing the need to encourage prenatal patients to meet with their pediatrician or family physician prior to delivery for education on breast-feeding, preventive care, and care of the newborn infant.

The Committee submitted the following recommendations to the KMA Board of Trustees to be considered for inclusion in KMA's recommendations to the Governor's Task Force on Health Care Access and Affordability:

1. Insure that adequate funding is available for prenatal care and preventive care for infants.
2. Home health visits for newborn infants.
3. Reorganization of state government to establish a separate Cabinet for Health and legislation to encourage career officers in the Cabinet for Health Services.
4. Increased funding for childhood immunizations.

The Board adopted recommendations 1 and 4, and they were included in KMA's Plan for Health Care Reform and submitted to the Task Force in preparation for the 1992 special legislative session on health care.

Due to lack of information on the issue, the recommendation that home health visits be provided for newborn infants was not adopted by the Board. The Committee, at its next meeting, clarified its intent by noting that the recommendation was for home health visits for socially and medically needy, high-risk newborns. The Cabinet for Human Resources currently tracks every high-risk newborn discharged from a Level II or Level III nursery. The Committee recommends that all high-risk newborns covered by Medicaid be followed by public home health nurses to insure PKU testing, infant immunizations, access to the WIC program, preventive care, and repeat pregnancy education. The Committee believes that referrals for this type of program should be physician initiated. Private physician delivery should not be affected and private physicians could contact the health department for patients needing this type of care. The goal of such care would be to decrease infant mortality in the state. The Committee believes that the issue should be reconsidered and that KMA should support public home health nurse visits for socially and medically needy, high-risk newborns.

The Committee's recommendation of KMA supporting reorganization of state government to establish a separate Cabinet for Health and legislation to encourage career officers in the Cabinet for Health Services also was not adopted by the Board. The intent of the recommendation was to coordinate Medicaid services for Kentucky's children by uniting *all* services into one program in the best interest of the children. The Committee felt this could be better accomplished by the protection of the jobs of quality public health employees rather than political appointments. Due to the special session on health care, the timing of this matter precluded the Board's adoption of the Committee's recommendation. The Committee recommends that KMA research and study the practicality

of a separate Cabinet for Health Services in state government.

Legislation passed during the 1992 regular session of the legislature which addressed maternal and child health was reported to the Committee by Patricia K. Nicol, MD, Director of Maternal and Child Health, CHR Department of Health Services. She reported the following:

1. Birth Defects Registry — HB 372 establishes a birth defects registry with an advisory committee to CHR to implement the registry. Data will be obtained from the Department of Vital Statistics and hospital records, and all infant death certificates in Kentucky will be compared to the birth certificate to ascertain that birth defects are properly recorded at birth. The collection could result in the development of preventive measures to decrease their incidence.

2. Substance Abuse During Pregnancy — HB 192 requires all vendors of alcoholic beverages to post signs warning expectant mothers of the dangers of alcohol use during pregnancy. Physicians will also be required to post this same sign in their waiting rooms.

3. 1992 Maternal and Child Health Division Budget — The budget has been increased to include additional funds for AIDS education, follow-up care for breast and cervical cancer patients, pre-conceptual care, and family planning.

Recognizing the importance of obstetrical training in family practice residency programs, the results of a 1989 survey of Kentucky OB/GYNs and family practitioners who deliver obstetrical care will be made available to the Governor's Task Force on Health Care Access and Affordability. The survey will be conducted again in 1992 and every five years thereafter. Data from the 1992 survey will be available to the KMA House of Delegates in 1993.

We appreciate the support the membership and the Board of Trustees have provided the Committee during the year. The 1992-93 Associational year will be a busy time for this Committee as we direct our resources toward those issues relating to maternal and child health.

J. Gregory Cooper, MD
Chairman

Recommendations:

1. The Committee on Maternal and Child Health recommends that all high-risk newborns covered by Medicaid be followed by public home health nurses to insure PKU testing, infant immunizations, access to the WIC program, preventive care, and repeat pregnancy education.
2. The Committee on Maternal and Child Health recommends that KMA research and study the practicality of a separate Cabinet for Health Services in state government.

Recommendations, Reference Committee 5:

Reference Committee No. 5 reviewed the Report of the Committee on Maternal and Child Health and its Recommendations No. 1 and 2. The Reference Committee recommends that Recommendation No. 1 be amended as follows.

The Committee on Maternal and Child Health recommends that all high-risk newborns covered by Medicaid be followed by public home health nurses their physicians and their designates to insure PKU testing, infant immunizations, access to the WIC program, preventive care, and repeat pregnancy education. The importance of preventive health measures, including immunization, is recognized for all infants and children in the Commonwealth.

Reference Committee No. 5 recommends adoption of Recommendation No. 1 as amended.

The Reference Committee reviewed Recommendation No. 2 of the Committee on Maternal and Child Health, and within the context of current health care reform, recommends it be adopted.

Reference Committee No. 5 recommends that the balance of the Report of the Committee on Maternal and Child Health be filed.

The Reference Committee would like to thank the members of the Committee on Maternal and Child Health for their devoted efforts on behalf of the families of the Commonwealth.

RESOLUTION F

School Health Clinics

Floyd County Medical Society

RESOLVED, that the Kentucky Medical Association seek necessary funding and administrative commitment from government sources to provide for clinics to be conducted in schools to teach disease prevention and control and healthy lifestyle issues.

Recommendations, Reference Committee 5:

Reference Committee No. 5 considered Resolution F, School Health Clinics, introduced by the Floyd County Society and recommends that the following substitute "Resolved" be adopted in place of the existing "Resolved":

"RESOLVED, that the Kentucky Medical Association seek administrative and legislative commitment to amend the Kentucky Education Reform Act (KERA) to require schools (grades K-12) to include health education in the curriculum."

Reference Committee No. 5 recommends adoption of Resolution F, as amended.

RESOLUTION G

Family Violence

Floyd County Medical Society

RESOLVED, that the Kentucky Medical Association seek necessary government funding to provide social and educational resources to families to prevent ongoing cycles of abuse.

RESOLUTION S

Family Violence

KMA Board of Trustees

WHEREAS, the Kentucky Medical Association, under the auspices of the Committee on Community and Rural Health, has appointed a "Blue Ribbon" Subcommittee on Domestic/Interpersonal Violence; and

WHEREAS, the Subcommittee is a multidisciplinary group composed of physicians, the Attorney General, the Fayette County Commonwealth Attorney, the Jefferson County Attorney, and representatives from the YWCA Spouse Abuse Center, the Kentucky Domestic Violence Association, and the Kentucky Department for Social Services; and

WHEREAS, the KMA has developed educational brochures to help physicians recognize and report child and elderly abuse; and

WHEREAS, the KMA is working with the Attorney General's Task Force on Domestic Violence to lessen the occurrence of abuses; now therefore be it

RESOLVED, that KMA further educate physicians on recognizing symptoms of abuse and understanding reporting laws pertaining to domestic/interpersonal violence in order to stem the ongoing cycles of abuse; and be it further

RESOLVED, that KMA urge all county medical societies to work

with local committees to educate communities on the serious issue of domestic/interpersonal violence.

Recommendations, Reference Committee 5:

Reference Committee No. 5 next heard testimony regarding Resolution G, Family Violence, introduced by the Floyd County Medical Society, and Resolution S, Family Violence, introduced by the KMA Board of Trustees.

The importance of physician and public education regarding issues of family violence was discussed, and the Reference Committee feels that the goals of increased awareness and prevention are best addressed in Resolution S.

Reference Committee No. 5, therefore, recommends Resolution S be adopted in lieu of Resolution G.

RESOLUTION Q

Tax-Free Income for Services to Medicare/Medicaid Patients

J. Gregory Cooper, MD, Chairman

KMA Young Physicians Steering Committee

WHEREAS, it is becoming increasingly more difficult to recruit physicians to rural areas of many states, including Kentucky; and

WHEREAS, physicians may avoid practice in rural and underserved areas of Kentucky due to high populations of Medicare and Medicaid patients with correspondingly low reimbursement rates; and

WHEREAS, it is desirable to consider new incentives that would improve access to care and availability of physicians in rural and underserved areas; now therefore be it

RESOLVED, that the Kentucky Medical Association investigate the feasibility of seeking legislation that would exempt physician income earned from providing services to Medicare and Medicaid patients in rural and underserved areas from federal and state income taxes.

Recommendations, Reference Committee 5:

Reference Committee No. 5 next reviewed Resolution Q, Tax-free Income for Services to Medicare/Medicaid Patients, introduced by J. Gregory Cooper, MD, as Chairman of the KMA Young Physicians Steering Committee. The Reference Committee acknowledges there is difficulty in recruitment and retention of physicians in rural areas. However, testimony was heard that this approach had been previously investigated and would require changes in both state and federal statutes in order to be implemented.

Reference Committee No. 5, therefore, recommends that Resolution Q not be adopted.

Mr Speaker, Reference Committee No. 5 recommends the adoption of the report of Reference Committee No. 5 as a whole.

Mr Speaker, I would like to thank the members of this Committee, John F. Allnutt, MD, Crescent Springs; James D. Crase, MD, Somerset; Elvis S. Donaldson, Jr., MD, Lexington; and Beverly M. Gaines, MD, Louisville, for the time and thoughtful consideration of the issues referred to the Reference Committee. The Chair would also like to thank Doris Crume for her assistance in the preparation of this report.

Respectfully submitted,

REFERENCE COMMITTEE No. 5

Jane R. Bramham, MD, Bowling Green, Chair

John F. Allnutt, MD, Crescent Springs

James D. Crase, MD, Somerset

Elvis S. Donaldson, Jr., MD, Lexington

Beverly M. Gaines, MD, Louisville

Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE NO. 6

John W. Collins, MD, Lexington, Chairman

- 34. Report of the Judicial Council
- 35. Report of the Rural Kentucky Medical Scholarship Fund
- 36. Report of the Physician-Attorney Liaison Committee
- 37. Report of the Membership Committee
- 38. Report of the Young Physicians Steering Committee
- 39. Report of the Medical Student Section
- 40. Report of the Resident Physicians Section
- 41. Report of the EMCK Foundation
- Resolution M — Designation of Psychiatry as Primary Care for RKMSF
(KMA Resident Physicians Section)
- Resolution R — Advanced Registered Nurse Practitioner (ARNP) Prescribing Privileges
(Board of Trustees)

ITEMS FOR CONSENT

Reference Committee No. 6 reviewed the following items and recommends they be filed, by consent of the House, without discussion:

- 34. Report of the Judicial Council — filed
- 36. Report of the Physician-Attorney Liaison Committee — filed
- 38. Report of the Young Physicians Steering Committee — filed
- 39. Report of the Medical Student Section — filed

Mr Speaker, Reference Committee No. 6 recommends adoption of the Consent Calendar as a whole.

Report of the Judicial Council

The Judicial Council did not see a great deal of activity this year, as fewer patient complaints were received. Only one complaint has required formal involvement by the Council. However, the Council did consider several policy issues, and its opinions in these matters will be covered in this report.

One complaint the Council considered relates to care rendered to a four-month-old child for fever and irritability. The child was hospitalized, but the family subsequently transferred care of the patient to another physician because of dissatisfaction with the treatment being provided. Based on information gathered by the area Trustee and comments provided by the second physician, it appeared that the initial diagnosis was correct, but the relationship between the physician and the patient's family had deteriorated. This case remains under investigation.

In other matters, the Council considered Ethical Guidelines on Gifts from Industry issued by the American Medical Association (AMA), particularly as they relate to gifts to charitable organizations on behalf of physicians participating in a meeting or on an advisory panel. It was the opinion of the Council that such a donation would not be unethical if the following conditions were met:

- 1. Each individual must determine the substantiality of the donation based on the amount of services provided.
- 2. The donation must be predetermined by the industry providing the gift, and may never be made in response to a previous commitment between the physician and the charity.
- 3. The gift must not influence the physician's position on a particu-

lar product's qualifications in any way.

4. The physician must provide an actual service, such as speaking or consulting, as opposed to merely attending a seminar.

In December, the Council reviewed a statement issued by the AMA Council on Ethical and Judicial Affairs on physician conflict of interest relating to referral of patients to facilities in which the physician has a financial interest. This report placed strong limitations on self-referral. By contrast, Resolution 5, adopted by the AMA House of Delegates at its 1992 Annual Meeting, was much more lenient. At a recent meeting of the Council, both positions were considered in order to provide guidance to the KMA Board of Trustees on this issue.

It was noted that the report of the AMA Council on Ethical and Judicial Affairs does provide for exceptions to the ban on physician involvement and referral to an outside facility, if there is a demonstrated need in the community for the facility and alternative financing is not available. The Committee supported the report of the AMA Council in lieu of Resolution 5.

Resolution W, adopted by the 1991 House of Delegates, was referred to the Judicial Council for consideration. This Resolution called for assurance that a physician serving as a consultant or an expert witness is qualified to do so. The Council endorsed the Resolution and referred it to the Board of Medical Licensure with a recommendation that appropriate guidelines be developed.

Finally, the Council considered several reports on ethics adopted by the AMA House of Delegates in June. These included Report C, "Confidentiality of HIV Status on Autopsy Reports," which seeks to protect the confidentiality of the decedent and the health and safety of the family and other contacts; Report G, "Confidential Care for Minors;" Report H, "Mandatory Parental Consent to Abortion," which advises physicians to follow state law, or in the event there is no governing state law, recommends encouraging parental involvement without mandating it; and Report I, "Treatment Decisions for Seriously Ill Newborns."

The Judicial Council felt that these were thoughtful reports which appeared to cover all contingencies. The Council concurred with all of these reports.

Once again, the Council noted that many patient complaints are generated by a lack of rapport between physicians and patients, often due to inadequate communication. Physicians are urged to increase efforts to establish and maintain good patient relations.

As Chairman, I would like to thank the Council members for their efforts throughout the year, and acknowledge the work of the Trustees who assisted in the investigation of patient complaints.

Will W. Ward, Jr, MD
Chairman

Report of the Physician-Attorney Liaison Committee

The Physician-Attorney Liaison Committee's major responsibility is resolving complaints between the two honored professions. During the 1991-92 year, we are pleased to report that no formal complaints were received. We continue printing the Interprofessional Code in the *Journal* on a biennial basis and provide copies of the Code to anyone upon request. It is apparent that both professions are aware of the Code and generally understand its provisions.

We thank the House of Delegates for the opportunity to serve and look forward to fulfilling its objectives in the coming year.

Lynn L. Ogden, MD
Chairman

Report of the Young Physicians Steering Committee

The Young Physicians Steering Committee met on May 19, 1992, to discuss ways to identify and address issues of interest to young physicians and increase young physicians' involvement in organized medicine.

In 1987, the AMA Young Physicians Section was formed to provide young physicians with a direct voice in policy decision making in all levels of organized medicine to insure that such policies appropriately reflect the unique perspectives of young physicians. The Section was formed to establish an ongoing presence for young physicians throughout all levels of organized medicine, to foster awareness of the unique needs and concerns of young physicians, and to insure continuing opportunities to address such needs and concerns. It was hoped that the Section would strengthen the broad-based support of organized medicine by young physicians to increase membership levels, accomplishing this by encouraging state medical societies to develop either sections, committees, and/or study groups.

A Young Physicians Steering Committee was appointed to accomplish the goals outlined by the AMA-YPS by identifying those young physicians throughout the state interested in being appointed to positions of participation and leadership through committees and other activities of the Association.

A special young physicians luncheon meeting was held last year during the KMA Annual Meeting in Lexington with S. William Clark, MD, Chairman, AMA-YPS Governing Council, as the featured speaker. Invitations were sent to all young physicians and their spouses in the state, and although the attendance was low, it was felt that the meeting was worthwhile. A second luncheon meeting for young physicians is scheduled for this year on Tuesday, September 15, 1992, beginning at 12:00 noon, at the Hyatt Regency Hotel in Louisville. Joy Maxey, MD, Atlanta, Georgia, Chairman-Elect of the AMA-YPS, has been invited to speak at this year's luncheon.

Two new bills were introduced in the US Senate and House of Representatives this spring in an expanded effort to repeal inequitable Medicare payment cuts for "new physicians." Senator John McCain introduced S 2362 to repeal provisions of current law that mandate Medicare payment reductions for physicians in their first four years of practice. To conform with "pay as you go" provisions in the 1990 budget agreement, S 2362 contains budget neutral language and directs the Secretary of Health and Human Services to make reductions in aggregate Medicare payments paid pursuant to the physician payment schedule to offset increased spending. Representative Ed Towns has introduced HR 4507 which contains budget neutral language and is identical to the McCain bill.

Background information on these two bills was sent to the YPS Steering Committee encouraging them to contact their Senators and Representatives asking for support of these bills. According to the AMA-YPS office, to date, 149 cosponsors have been received for HR 4507 and 27 cosponsors have been received for S 2362. Letters from the Steering Committee were also sent to all Kentucky Senators and Representatives in support of these bills.

KMA continues to send a Delegate and Alternate Delegate to the AMA-YPS meetings representing Kentucky young physicians at the AMA level. At the 1991 AMA Annual Meeting in Chicago, Michael Watts, MD, Carrollton, attended as Delegate, and Greg Cooper, MD, Cynthiana, attended as Alternate Delegate. At the 1991 Interim Meeting, Michael Watts, MD, Carrollton, attended as Delegate, and Ray Hart, MD, Louisville, attended as Alternate Delegate. At the 1992 Annual Meeting, Ford Threlkeld, MD, Bowling Green, attended as

Delegate.

Special ribbons have again been order to identify young physicians attending the KMA Annual Meeting this fall. The AMA defines a young physician as being under the age of 40 or in the first five years of professional practice.

The Committee appreciates the continuing support of the KMA Board of Trustees and officers of the Association.

J. Gregory Cooper, MD
Chairman

Report of the Medical Student Section

Although the Governing Council of the KMA Medical Student Section did not meet formally in 1991-92, the individual chapters at the two medical schools were active in a number of state and national activities.

Both the University of Louisville and University of Kentucky MSS chapters received Outreach Program Awards at the 1991 AMA Interim Meeting in Las Vegas for their recruitment of medical students to the AMA. Over 20 medical students represented Kentucky at the AMA-MSS Interim and Annual Meetings this year and were pleased that Kentucky continued to be represented nationally by UL medical student, Christa-Marie Singleton, who served this year on the AMA-MSS Governing Council.

One of the issues of major concern to students and residents during the past several years dealt with changes in student loan deferment brought about by the Reauthorization of the Higher Education Act (HEA). Medical students and residents have been involved in an extensive grassroots campaign to bring improvements in the HEA for a number of years and are pleased to claim victory with the latest conference committee report on the HEA. The number of letters and phone calls to members of Congress were instrumental in obtaining favorable results on loan deferment and forbearance.

University of Kentucky — In addition to activities at the national level, the UK Chapter of the KMA-MSS was actively involved in the 1991 joint annual meeting of the KMA MSS/RPS held October 3 in Lexington. We want to acknowledge the help provided by the UK Office of Education, the Fayette County Medical Society, and Preston Nunnolley, MD, in making it possible for a large number of UK medical students to attend this meeting. Matt Shotwell served as the Chapter President this year.

University of Louisville — Daniel Wilds, President of the UL KMA-MSS, reports that the 1991-92 school year was an active one for the UL students as it became a year for change with the goal of increasing student involvement and awareness. Projects included letter-writing campaigns to state and national legislators focused on legislative action pertaining to students, structural reorganization to involve more students in each of the four classes with increased leadership positions for the first-year student, and long-term planning for the role of the state Governing Council in conjunction with the University of Kentucky.

Goals for the upcoming year include an increased emphasis on outreach to our fellow students; increased accessibility to AMA/KMA resources by establishing a section in the Health Sciences Library devoted to the AMA/KMA Medical Student Section; increased numbers of students in attendance at local, state, and national meetings, possibly coordinated with fundraising events to make attendance possible; and creation of a UL KMA-MSS newsletter to keep clinical and basic science students informed of events and activities.

As always, we remain thankful and indebted to the KMA for its continuing support and look forward to the coming year.

Matt Shotwell
President

END OF CONSENT CALENDAR ITEMS

Report of the Rural Kentucky Medical Scholarship Fund, Inc

The Rural Kentucky Medical Scholarship Fund, Inc. (RKMSF) attempts to meet the medical needs of the rural population by alleviating the maldistribution of physicians. RKMSF currently administers two worthwhile programs in its efforts to meet this goal.

The first program provides low interest loans to medical students. Any loan recipient who practices primary care medicine in a county in critical need of physicians will be forgiven one loan for each full year of practice in the approved county. Any recipient practicing in a designated rural county facing a primary care physician shortage which is less than critical must repay his/her loans at a discounted interest rate which is determined yearly (currently 3.25%). Interest accrues from the date of the loan until payment is due.

For the school term 1992-93, the RKMSF made scholarship loans to 8 new applicants in the amount of \$10,000 each at 3.25% interest, and 18 loans to prior student recipients. A total of \$260,000 was expended in scholarship loans for 1992-93. In 1991-92, \$260,000 was also expended.

Since its inception in 1946, the Rural Kentucky Medical Scholarship Fund has granted 560 loans. There are currently 42 medical students/residents who have received loans from the RKMSF. The loans are granted for an 8-year period. Five recipients are entering residency programs in 1992 — three in family practice and two in pediatrics. Seven recipients are currently enrolled in residency programs, and three recipients are entering practice in 1992. The remaining 27 recipients are currently in medical school.

There were eight recipients who received forgiveness for loans in 1991-92, and seven recipients completed their financial and/or practice obligations in 1991-92.

The second program administered by RKMSF is the Establish Practice Grant Program (EPGP). The EPGP provides money to practicing physicians to assist in paying prior educational loans. For each year a physician in the EPGP practices in a critical county, he/she will be granted \$10,000 to be used toward an educational debt, with a maximum of \$40,000 granted per physician.

Five physicians are currently participating in the EPGP. One physician's participation in the EPGP has been completed. A second EPGP participant has moved from the critical county and is no longer eligible. There are two new participating physicians in the EPGP this year. Upon completion of a year of practice, each physician received a grant of \$10,000 to help defray his/her educational debt. The physicians are practicing in the counties of Adair, Knott, Menifee, Spencer, and Grant.

The RKMSF has two main sources of income: interest accrued on the scholarship notes which are paid back or bought out and interest on investments. The average maturity of RKMSF investments is just under two and one-half years, with an average yield of 8.63%.

The Kentucky Medical Association continues to provide its support which greatly contributes to the success of the Fund. The RKMSF, while operated through the KMA, is a separate, nonprofit

corporation, having its own Officers and Board of Directors. This report is furnished as an informational item.

Donald R. Stephens, MD
President

Recommendations, Reference Committee 6:

Reference Committee No. 6 reviewed the Report of the Rural Kentucky Medical Scholarship Fund and commends the President, Don Stephens, MD, and his Board for an excellent report on the workings of the Fund.

Reference Committee No. 6 recommends that the Report of the Rural Kentucky Medical Scholarship Fund be filed.

Report of Membership Committee

The Membership Committee met on April 29, 1992, to review activities undertaken for the recruitment and retention of physicians, residents, and medical students in Kentucky and to recommend future programs to enhance membership development for the Association.

Although membership again reached an all-time high in 1991 with 5,660 total members, the number of Active members increased by only 23. Total dues-paying members only increased by 7, primarily due to the large number of members taking a dues-exemption for retirement or military status during Operation Desert Storm. More than 25% of KMA members were dues-exempt during 1991.

Excluding the loss of 164 Active members who left the state, retired, or died, the Committee is pleased to report that 98% of 1990 Active members rejoined last year. The number of new members for 1991 included 230 Active, 109 In-training, and 16 Associate. The addition of 108 residents who took advantage of the free 6-month membership offered at the Housestaff Orientations in June brought the total new members for 1991 to 463.

The most encouraging report at the end of 1991, however, was that 197 applications were awaiting approval by county medical societies and this is reflected in the mid-year report of membership for 1992, which already surpasses year-end 1991 figures in dues-paying members.

Membership Category	# as of 6/30/92	# as of 12/31/91	1/2
Active	3,865	3,743	(+122)
In-Training	276	286	(-10)
Associate/Inactive	232	213	(+19)
Total Dues-Paying	4,373	4,242	(+131)
Total Dues-Exempt	1,245	1,418	(-173)
TOTAL ALL CATEGORIES	5,625	5,660	(- 35)

The success of the 1992 membership year not only reinforces the importance of an ongoing and comprehensive membership plan, but reflects increased recognition by physicians of the significant role the Kentucky Medical Association has in their professional lives. Because of KMA's effective representation at the state and national levels, programs to assure quality care, and member services and benefits, the role of membership development is to effectively communicate these efforts and activities to all physicians.

The membership recruitment plan for 1992 included five statewide mailings, seven campaigns targeted to specific groups, and two peer-to-peer outreach programs, for a total of almost 8,300 individual contacts.

Young physician nonmembers were the target of several recruitment efforts this year. A demographic update on membership again revealed that the under-40 age group still accounts for the

largest number of nonmembers. It is encouraging to note, however, that 40% of all nonmembers in 1991 were under age 40, compared to 46% in 1990, and that 65% of all new Active members were in this age group.

The newly edited version of the KMA membership videotape was distributed in November to 278 young physicians. This recruitment vehicle, which was very successful when originally used in 1988 and 1989, received an almost 12% response, for 33 new members. This brings the total new members from the KMA videotape to 100 and an overall response rate of 11%. We continue to utilize this tool in recruitment efforts and assist other state and county medical associations with similar projects.

Several statewide recruitment mailings dealt with the legislative proposals and activities surrounding the 1992 Kentucky General Assembly. The response to these solicitations indicates that physicians are concerned about representation issues and support KMA's activities in this area. In addition, more than 400 personal letters were sent last year on a routine basis to physicians new to the state or just starting practice. More than half of those, or 203 physicians, joined KMA from these initial contacts.

The Committee feels strongly, however, that the most effective way to reach the population of nonjoiners is through personal contacts by other physicians. Several proposals for peer-to-peer recruitment were reviewed by the Committee at its April 29th meeting, including a statewide "Member-Get-A-Member" outreach program using personal incentives to increase member involvement in peer recruitment.

The Committee also agreed to participate in the "Women in Medicine Month" as proposed by the AMA for September and has solicited articles from a number of women leaders in the state to be published in *The Journal*. It was noted that 62% of practicing women physicians are KMA members, compared to overall membership of 76% of all physicians. A number of counties fall below that percentage, particularly Fayette County in which only 36% of the women physicians are members. While 12% of KMA's Active members are women, In-Training (resident) membership is composed of 36% female.

Retention is a vital part of the overall membership plan and received additional emphasis during 1992. An earlier billing cycle was implemented along with the initiation of a "Superbill" for physicians at four clinics in lieu of individual bill statements. We are grateful for the Clinic administration at Trover in Madisonville, Morgan-Haugh in Mayfield, Cave Run in Morehead, and Daniel Boone in Harlan for participating in the Superbill program as a more efficient manner of dues processing.

The Committee continues to support activities to involve residents and medical students in organized medicine. Almost 100 new residents were recruited during the Housestaff Orientations held June 23 at the University of Kentucky and June 30 at the University of Louisville. The Committee wishes to thank two members of the KMA Resident Physician Section Governing Council, Judy Linger, MD, (UK), and David Butler, MD, (UL), as well as KMA President, S. Randolph Scheen, MD, for representing organized medicine at this year's programs.

KMA student leaders of both medical schools received awards at the AMA Interim Meeting in December for their recruitment efforts which netted 121 student members for county, KMA, and AMA. Currently, 74% of Kentucky's medical students and 30% of residents are KMA members.

As a service to its members, KMA has sponsored eight practice management workshops (25 individual sessions) during 1991-92 with a total attendance of almost 900 physicians, spouses, and office

personnel. With the new Medicare payment system instituted in 1992, half of these sessions dealt primarily with RBRVS and the new Evaluation and Management Codes. The Committee is planning to increase the number of workshop offerings during the next year and will include seminars on financial management and retirement.

A strong membership base is essential to the success and ability of the Association to fulfill its mission of service to the profession and the public. We must all effectively and continually communicate the efforts being made by organized medicine on behalf of *all* physicians. Part of being involved in organized medicine is having a commitment to work for common goals and ideals. Encouraging others to do the same is also part of that commitment and responsibility.

**Harold D. Haller, Sr, MD
Chairman**

Recommendations, Reference Committee 6:

Reference Committee No. 6 next considered the Report of the Membership Committee and heard a lively discussion on membership issues. It was noted that young physicians comprise the largest percentage of nonmembers and the costs of belonging to multiple specialty and professional associations may be a major factor in low membership of this group. To address these issues, the Reference Committee suggests that the Membership Committee review the dues structure and encourage medical schools to create mentor groups with professors, residents, and medical students. The Reference Committee feels that medical faculty active in KMA would be excellent role models for organized medicine for medical students and residents. Reference Committee No. 6 would like to thank Chairman Harold Haller, MD, and his Committee for the amount of work and effort they have put into membership development.

Reference Committee No. 6 recommends that the Report of the Membership Committee be filed.

Report of the Resident Physicians Section

The KMA Resident Physicians Section has been very active at the state and national levels during the past year. The Governing Council, made up of representatives from the four residency programs in the state, has met on three occasions and has had strong representation at the KMA Annual Meeting as well as the AMA Interim and Annual Meetings.

The KMA-RPS and Medical Student Section held a very successful joint session on October 3 which attracted over 175 residents and students from Kentucky. A lively debate on the topic of resident work hours was the highlight of the session which featured Ward Griffen, MD, Executive Director of the American Board of Surgery, and William Johnstone, MD, AMA-RPS Secretary-Treasurer.

The Section continues to be effective in developing policy for adoption at the state level and was fortunate to have a number of residents speak on behalf of RPS Resolutions before the 1991 House of Delegates. The Resolutions, which dealt with Hepatitis B immunization policy for medical students, legislation to prohibit publication of rape victim names, and prenatal preventive care education, were all adopted and are being implemented by the appropriate KMA committees.

At its meeting on January 28, the Governing Council was privileged to have Walter I. Hume, Jr, MD, Medical Director of the Kentucky Medical Insurance Company, discuss the medical malpractice climate in Kentucky and various risk prevention skills that residents could incorporate during their training. In addition to Doctor Hume's informative presentation, the Council elected its

1992 officers, heard an update on activities of the Kentucky General Assembly, and reviewed issues brought before the AMA-RPS Assembly in December.

The Council met on April 21 to finalize plans for the 1992 RPS and MSS Annual Meeting to be held September 15. Randolph Starks, from Kentucky Medical's Risk Management Office, will deal with ways to avoid lawsuits and Clifford Kuhn, MD, Louisville psychiatrist and comedian, will talk on the humorous side of medicine.

National legislative issues were also discussed at the April meeting as Council members have been extensively involved in the grassroots campaign regarding student loan deferments. Council members not only wrote individual letters, but also made personal contacts through telephone calls and Congressional visits. Letters were also sent from the leadership of the KMA-RPS and MSS to Kentucky's Congressional Delegation and we are pleased to report that many positive elements sought by the AMA were included in the conference version of the Reauthorization of the Higher Education Act.

The 1992 AMA-RPS Annual Meeting, held June 19-21 in Chicago, was a major highlight for KMA residents. For the first time, three residents represented Kentucky at this meeting, and we want to express appreciation for the support of Alfred Thompson, MD, and the University of Louisville in providing funding for Council member William Roy, MD, to attend.

We are also pleased to report that David Butler, MD, KMA-RPS Chairperson, was a recipient of a Burroughs Wellcome Company Leadership Program Award. The award, which is a stipend to attend AMA-RPS meetings, is given to residents who have demonstrated a commitment to civic or medical community issues through voluntary activities and have an interest in organized medicine.

The Kentucky Section is extremely proud to report that Judy Linger, MD, KMA-RPS Delegate to the 1992 meeting, was elected as an At-Large member of the AMA-RPS Governing Council. Although Doctor Linger has held a national post as a past chairperson of the AMA Medical Student Section Council, it is the first time the KMA-RPS has had an officer at the AMA level.

In late June, KMA again participated in the Housestaff Orientations at UK and UL; however, this was the first year that RPS Council members were involved in the programs. We are grateful for the presentations made by Doctors Linger and Butler to their colleagues on June 23 and June 30 on behalf of organized medicine.

At its meeting on July 21, the Council formulated Resolutions for submission to the 1992 KMA House of Delegates and heard reports from those attending the AMA-RPS Annual Meeting. Final plans were made for a statewide RPS newsletter to promote the Annual Meeting program and to present issues of current interest to residents.

As President, I appreciate the opportunity to represent the Section at meetings of the KMA Board of Trustees and, on behalf of the Council, want to thank the House of Delegates and individual members of KMA for their continued support.

**Sheryl M. Schneider, MD
President**

Recommendations, Reference Committee 6:

Reference Committee No. 6 reviewed the Report of the Resident Physicians Section and recognizes the election of Judy Linger, MD, Lexington, to the Governing Council of the AMA Resident Physicians Section. Reference Committee No. 6 would like to thank RPS President Sheryl Schneider, MD, for her report.

Reference Committee No. 6 recommends that the Report of the Resident Physicians Section be filed.

Report of the Ephraim McDowell Cambus-Kenneth Foundation

The Ephraim McDowell Cambus-Kenneth Foundation, was incorporated on May 26, 1988, as a not-for-profit Kentucky corporation and exists exclusively for "charitable and educational purposes in promoting an appreciation of history through the acquisition, restoration, and preservation of buildings and properties having special historic significance."

The Foundation was formed by the Kentucky Medical Association for the purpose of accepting from Mr. Joe A. Wallace and Mrs. Cecil Dulin Wallace upon their deaths the 550-acre Cambus-Kenneth farm located in Danville. This farm was at one time owned by the pioneer physician, Ephraim McDowell, MD; served as his summer home; and was the site of his death. In addition, the assets of the former McDowell Memorial Fund, including the McDowell House and Apothecary Shop, also in Danville, were conveyed by the Kentucky Medical Association to this Foundation.

The corporation's Board of Directors met in July of this year. The first item of business was the election of the Foundation's corporate officers to include S. Randolph Scheen, MD, President; William B. Monnig, MD, Vice President; and William P. VonderHaar, MD, Secretary/Treasurer.

The Board amended the Foundation's Bylaws, changing the date of the Foundation's annual meeting to correspond with the KMA Annual Meeting. This will allow for a simultaneous change of the Foundation's officers with that of the KMA. Therefore, the next annual meeting of the Foundation will be Thursday, September 17, at the conclusion of the KMA Annual Meeting.

The McDowell House Managers Committee now operates under the auspices of the Foundation to supervise the maintenance and operation of the McDowell House and Apothecary Shop. A report of the financial status of the McDowell House was presented to the Board in July. Finances seem to be in good order, with donations by "Friends of the McDowell House" totaling \$14,310 for 1991, with an additional \$10,200 contributed by the Friends from January to June 1992. The endowment fund value is approximately \$190,000. The Managers Committee is putting additional emphasis on the Friends project in an attempt to increase the number of the Friends' participants. A report was also given on repairs made to the McDowell House during the year. In addition, changes in membership of the McDowell House Managers Committee were also approved. The Committee continues to meet on a quarterly basis, and two members of the Committee are elected to serve with the chairman as board members of the Ephraim McDowell Cambus-Kenneth Foundation.

Mr James C. Thomas, who has been a long-time member and valued resource for the Managers Committee, resigned for personal reasons in October of last year. Nancy Swikert, MD, and Mrs Jo-Ann Daus have been added to the Committee as representatives of the Kentucky Medical Association Auxiliary and have taken active roles on the Committee. Porter Mayo, MD, and Mrs Robert Rouse have resigned from the Managers Committee. Mrs Rouse has been replaced by Mrs Albert Bryant Kausner as the representative of the Colonial Dames. An increase in the annual gift from the Kentucky Medical Association from \$8,500 to \$10,000 per year helped offset increases in maintenance and employee expenses, as well as the loss of annual gifts from other medically related associations.

The Auxiliary has continued to play an important role in maintaining and adding to the collection of the McDowell House and has been very faithful in its participation. Thomas Courtney, MD, Louisville, agreed to replace James Thomas as Chairman of the

Furnishings Committee. This is a very demanding job and one which requires a lot of time.

The Foundation's Planning Committee met in May of 1992 with Joe Wallace, the current owner of the Cambus-Kenneth farm. The Planning Committee was originated in 1991 in order to study the feasibility of beginning a Foundation project at the farm during the Wallace lifetimes. Mr and Mrs Wallace have graciously agreed to leave the Cambus-Kenneth farm, as well as additional assets, to the Foundation upon their deaths. Mr Wallace reported that the farm is enjoying a successful year and announced he is hopeful of adding to his existing equine operations. The Planning Committee and Mr Wallace agreed that due to financial restraints on the Foundation, no projects would be considered in the near future as was previously contemplated. I would like to give special thanks to David Kinnaird, MD, who has devoted a great deal of time as Chairman of the Planning Committee.

The Foundation Board would like to thank Russell Shearer, MD, Chairman of the McDowell House Managers Committee, as well as the Committee members and the McDowell House volunteers and staff who have made the operation of the Foundation a success.

S. Randolph Scheen, MD
Chairman

Recommendations, Reference Committee 6:

Reference Committee No. 6 next considered the Report of the Ephraim McDowell Cambus-Kenneth Foundation, Inc, and thanks S. Randolph Scheen, MD, Chairman, and the members of the Foundation Board for a very informative report.

Reference Committee No. 6 recommends that the Report of the Ephraim McDowell Cambus-Kenneth Foundation, Inc, be filed.

RESOLUTION M

Designation of Psychiatry as Primary Care by RKMSF KMA Resident Physicians Section

WHEREAS, there is a significant problem of access to medical care in rural and certain urban areas of Kentucky; and

WHEREAS, family physicians and others designated as "primary care" physicians serving in these areas carry a tremendous load in meeting the medical needs of their patients; and

WHEREAS, no psychiatric physicians currently serve in the counties designated in critical need of physicians; and

WHEREAS, there are increasing needs among the population (victims of abuse, child and adolescent problems, mental health problems of the homeless, substance abuse, and others) for specific treatment which those trained in psychiatry can provide, often on an outpatient basis; and

WHEREAS, there are more psychopharmacological treatments for chronic mental illnesses which have been shown to decrease the number of hospitalizations and, therefore, decrease the cost of caring for these patients; and

WHEREAS, the Rural Kentucky Medical Scholarship Fund provides incentives through scholarships and practice grants to "primary care" physicians to serve in counties in critical need of medical care; now therefore be it

RESOLVED, that KMA ask the Rural Kentucky Medical Scholarship Fund to consider including physicians who are trained in psychiatry in its definition of "primary care."

Recommendations, Reference Committee 6:

Reference Committee No. 6 considered Resolution M, Designation of Psychiatry as Primary Care for RKMSF, submitted by the KMA

4th District Trustee	Salem M. George, MD Lebanon
4th District Alternate	R. Kent Collard, MD Elizabethtown
12th District Trustee	Scott B. Scutchfield, MD Danville
12th District Alternate	Don E. Brown, MD Somerset
14th District Trustee	E. D. Roberts, MD Pikeville
14th District Alternate	Vivente B. Santelices, MD Pikeville

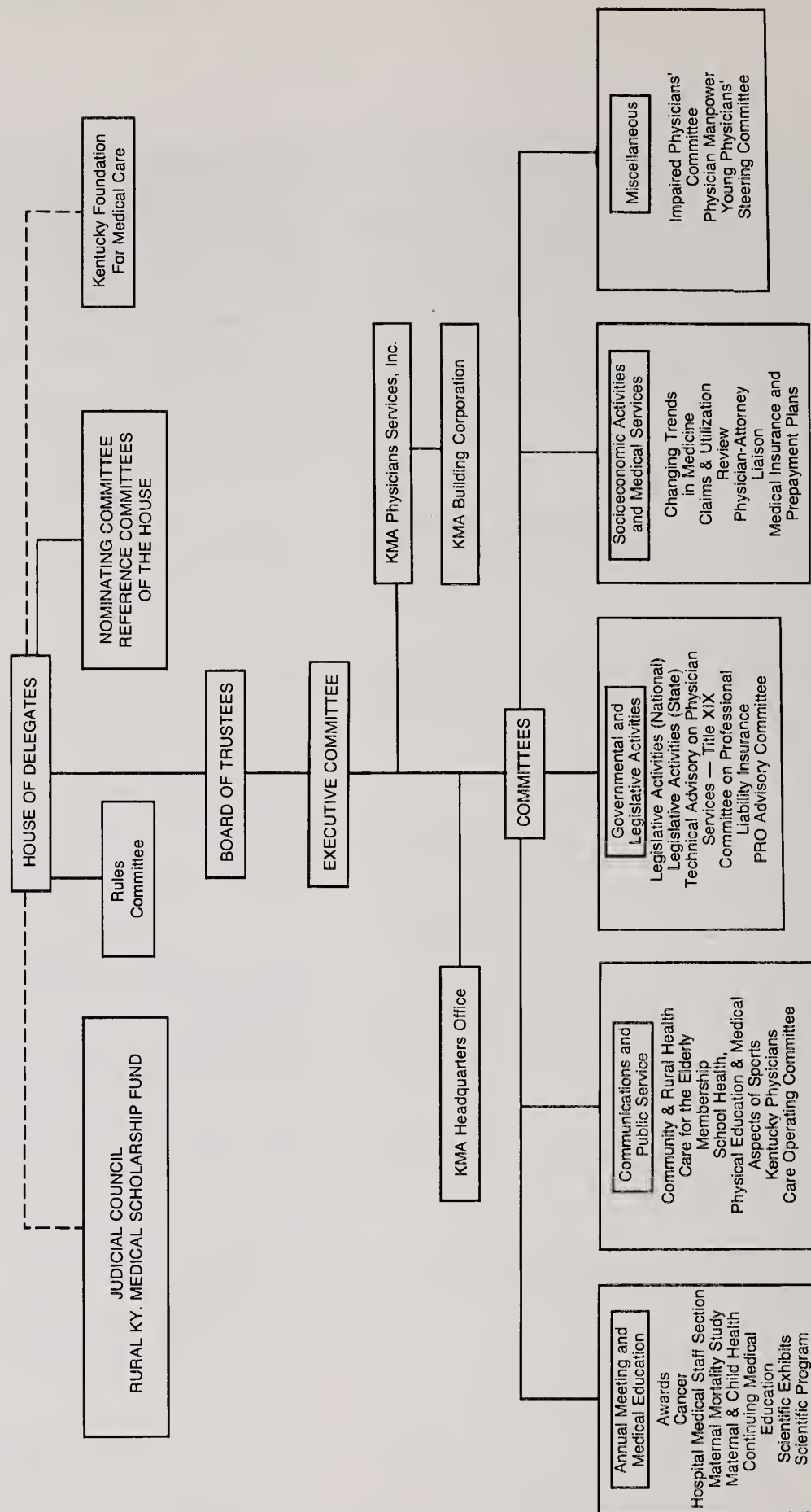
Election of 1993 Nominating Committee

The following physicians were elected by the House of Delegates to serve as the 1993 KMA Nominating Committee:

Joseph G. Weigel, MD, Somerset, Chairman
John V. Borders, MD, Lexington
William C. Harrison, MD, Owensboro
John M. Karibo, MD, Louisville
Frank K. Sewell, Jr, MD, Henderson

Speaker Clark adjourned the 1992 Session of the KMA House of Delegates at 9:25 PM.

KMA Organization Chart—Revised September 1992



CONSTITUTION AND BYLAWS OF THE KENTUCKY MEDICAL ASSOCIATION

CONSTITUTION

Article I.	Name of the Association
Article II.	Purpose of the Association
Article III.	Component Societies
Article IV.	Composition and Meetings of the Association
Article V.	Officers
Article VI.	House of Delegates
Article VII.	Districts, Sections and District Societies
Article VIII.	Board of Trustees
Article IX.	Funds and Expenses
Article X.	Referendum
Article XI.	The Seal
Article XII.	Amendments
Article XIII.	Definitions

Article I. Name of Association

The name and title of this organization shall be the Kentucky Medical Association.

Article II. Purpose of the Association

The purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge; the advancement of medical science and charity; the evaluation of the standards of medical education; the enactment and enforcement of just medical laws; the promotion of friendly intercourse among physicians and the guarding and fostering of their material interests; the protection of the members thereof against unjust assaults upon their professional care, skill or integrity; and to the enlightenment and direction of public opinion in regard to the great problems of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

Article III. Component Societies

Component societies shall consist of those medical societies which hold charters from this Association.

Article IV. Composition and Meetings of the Association

The Association shall consist of the members of the component societies, but the House of Delegates shall have authority to adopt such bylaws regulating the admission and classification of members as it may deem advisable. The Association shall hold an Annual Meeting and such Special Meetings as may be called pursuant to the bylaws.

Article V. Officers

Section 1. The officers of this Association shall be a President, a President-Elect, a Vice-President, a Secretary-Treasurer, a Speaker and Vice-Speaker of the House of Delegates, a Trustee and an Alternate Trustee from each district that may be established; and such other officers as may be provided for in the Bylaws.

Section 2. The eligibility, duties and terms of office of all officers of the Association shall be as prescribed in the Bylaws.

Section 3. All officers shall serve until their successors have been elected and installed.

Section 4. All officers shall be elected by the House of Delegates at its Regular Session and shall take office on the last day of the Annual Meeting.

Article VI. House of Delegates

Section 1. The House of Delegates shall be the legislative body of the Association and shall have power, by a two-thirds vote of all the delegates present at that session, to adopt bylaws to carry out the provisions of this Constitution and to provide for the government of the Association in any other manner not inconsistent with this Constitution. It shall meet in Regular Session, annually during the Annual Meeting of the Association, and may

be called into Special Session under such conditions as may be prescribed in the bylaws.

Section 2. Delegates shall be members of and elected by component county societies in such a manner as may be provided in the Bylaws. Officers of the Association, Delegates and Alternate Delegates of the American Medical Association and five immediate Past Presidents shall be the ex-officio members of the House of Delegates and entitled to vote. All other Past Presidents and Vice-Presidents and Past Chairmen of the Board of Trustees shall be ex-officio members of the House. They shall have the right to speak and debate on the floor of the House but shall not have the right to make a motion, introduce business or an amendment, or vote.

Section 3. The House of Delegates shall elect a Speaker and a Vice-Speaker, one of whom shall preside during the meetings of the House of Delegates. The presiding officer shall not be entitled to a vote except in the event of a tie.

Section 4. The House of Delegates shall be the final judge as to the qualification of its members.

Article VII. Districts, Sections and District Societies

The House of Delegates shall divide the state into Districts composed of one or more counties, for administrative purposes. It may also provide for a division of the scientific work of the Association into appropriate Sections, and for the organization of such District Societies, composed exclusively of members of component societies, as will promote the best interests of the profession.

Article VIII. Board of Trustees

The House of Delegates shall make provision in the bylaws for a Board of Trustees composed of one Trustee from each District and such of the other officers of the Association as the House may deem appropriate, which shall be charged with the general direction of the Association's affairs during the interim between meetings of the House. The House may delegate such powers to the Board of Trustees as are not specifically required by this Constitution to be exercised by the House, and may limit the Board's powers to such extent as it may determine to be necessary or desirable, provided, however, that in no event shall the Board of Trustees have power to commit the Association to any course of action which is contrary to or at variance with any policy established by the House of Delegates.

Article IX. Funds and Expenses

The House of Delegates shall provide funds for meeting the expenses of the Association by such methods and from such sources as it may select. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session, for publications, and for such other purposes as will promote the welfare of the Association and the profession.

Article X. Referendum

The membership of the Association, by written petition signed by not less than 10% of the active membership, may obtain a referendum on any question pending before the House of Delegates. The Secretary-Treasurer, upon the presentation of such a petition to him shall cause the question to be submitted to the active membership by mail, and if a majority of the active members shall signify its approval or disapproval of a certain policy or course of action with respect to the question thus submitted, the will of the majority shall determine the question and shall be binding upon the House of Delegates and the Association upon certification of the result of the vote by the Secretary-Treasurer to the President and Board of Trustees.

Article XI. The Seal

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the Regular Session, provided

that such amendment shall have been presented in open meeting at the previous regular session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken.

Article XIII. Definitions

Whenever used in this Constitution, the Articles of Incorporation or the Bylaws—

(a) "County society," "component county society," or "component medical society" means "component society."

(b) "Annual Meeting" means the annual three-day meeting of the Association.

(c) "Scientific Sessions" mean those sessions during the Annual Meeting at which scientific subjects are programmed and discussed.

(d) "Regular Session" means the regular session of the House of Delegates which is held during the Annual Meeting.

(e) "Special Session" means a special, called meeting or session of the House of Delegates.

BYLAWS

Chapter I.	Membership
Chapter II.	Annual and Special Meetings of the Association
Chapter III.	The House of Delegates
Chapter IV.	Election of Officers
Chapter V.	Duties of Officers
Chapter VI.	Board of Trustees
Chapter VII.	Discipline-The Judicial Council
Chapter VIII.	Standing Committees and Councils
Chapter IX.	Assessments and Expenditures
Chapter X.	Rules of Conduct
Chapter XI.	Rules of Order
Chapter XII.	County Societies
Chapter XIII.	Amendments

CHAPTER I. MEMBERSHIP

Section 1. Membership in this Association shall be coterminous with membership in a component county society. No physician shall be eligible for membership in this Association unless he is a member, in good standing of a component society, nor may he maintain membership in a component county society unless he is a member, in good standing of this Association.

When a physician who meets the qualifications hereinafter set forth, is certified to the Secretary-Treasurer as a member in good standing of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary-Treasurer of the Association, the name of the member shall be included in the official roster of the Association and he shall be entitled to all the privileges of his class of membership. Provided, however, that members in good standing from other state societies may, if admitted to membership by a component society, be accepted by KMA for membership without paying dues for the remainder of the calendar year in which the transfer is made. Provided further, that the Board of Trustees shall have power, upon written application, approved annually by the county society of which the applicant is a member, to excuse any member from the payment of dues because of financial hardship. And provided further, that the Judicial Council, after a hearing, shall have power to condition membership in this Association upon the physician's agreement to limit the scope of his practice in any manner reasonably calculated to protect the public from the adverse effects of any demonstrated frailty or disability of said member.

Section 2. Membership in the Association shall be divided into nine classes, to wit: Active, Life, In-Training, Associate, Inactive, Student, Service, Honorary and Special.

(a) **Active Members.** The active membership of the Association shall consist of the active members of the various component medical societies. To be eligible for active membership in any component society, the applicant must be a physician who holds an unrestricted or limited license to practice medicine and surgery in this state, and who is of good moral, ethical and professional standing. Nothing contained herein shall prevent a component society from requiring new members to occupy provisional status for a reasonable time after their admittance to membership under any classification.

(b) **Life Members.** Component societies may elect as a life member any doctor of medicine or osteopathy who has served his profession with distinction and who has reached the age of 70 and has retired from active practice. Further, any member who has 25 years of continuous membership in a state medical society affiliated with the American Medical Association, who has reached the age of 65 and is fully retired, also may be elected as a life member. However, any member who had qualified as a life member at the time of the adoption of this amendment, September 26, 1990, shall continue to qualify as a life member. Life members shall have the right to vote and be entitled to the benefits of Chapter VI, Section 8, of these

Bylaws, but shall not pay dues. They shall receive *The Journal* and other publications of the Association.

(c) **Resident Physicians Section.** Doctors of medicine or osteopathy who have complied with all pertinent regulations of the Kentucky Board of Medical Licensure and who are serving in AMA approved training programs in Kentucky shall be eligible for membership in the Resident Physicians Section of the Kentucky Medical Association. The Resident Physicians Section shall be governed by its own Constitution and Bylaws, which shall not be in conflict with the Constitution, Bylaws and Board policies of the parent Kentucky Medical Association. Should any questions arise regarding the existence of a conflict, the KMA Board of Trustees shall be the final arbiter of such questions. In-Training members in good standing shall have the right to vote and receive all publications of the Association. In-Training members shall not be counted in determining the number of delegates to which their county society is entitled in the House of Delegates. The Resident Physicians Section will be represented in the KMA House of Delegates by one voting representative elected by the Governing Council of the Resident Physicians Section.

(d) **Associate Members.** The associate membership of the Association shall consist of the associate members of the various component medical societies. To be eligible for associate membership in any component society, the applicant must qualify under one or more of the following groups:

(1) Medical officers of the United States Army, Navy, Air Force, Veterans Administration, Public Health Service, or other federal governmental service while on duty in the State, but shall not be deemed to include physicians employed on a full-time basis by the Veterans Administration.

(2) Dentists may be invited to become Associate members.

(3) Physicians residing and/or practicing in communities bordering Kentucky who are active members of their home state and county society and who wish to become members of KMA on an other than active basis may become Associate Members.

Associate members shall not have the right to vote nor to hold office, but shall receive *The Journal* and other publications of the Association.

(e) **Inactive Members.** The inactive membership of the Association shall consist of the inactive members of the various component county societies. Any doctor of medicine licensed to practice medicine in Kentucky who is not engaged in the practice of medicine but who is otherwise eligible for active membership in the Association may be admitted to inactive membership by any component county society. Inactive members shall not have the right to vote nor hold office, but shall receive *The Journal* and other publications of the Association.

(f) **Student Members.** Any student in an accredited medical school in Kentucky or any resident of Kentucky who is a student in an accredited medical school in the United States shall be eligible for membership in the Medical Student Section of the Kentucky Medical Association. This Medical Student Section shall be governed by its own Constitution and Bylaws, which Constitution and Bylaws shall not be in conflict with the Constitution, Bylaws and Board policies of the parent Kentucky Medical Association. Should any questions arise regarding the existence of a conflict, the KMA Board of Trustees shall be the final arbiter of such questions. Membership shall be coincident with the academic enrollment of the student. Student members may not hold office in the State Association, but may be voting members of any State Association committee to which they are appointed. Student members may, however, hold office within the Student Section in accord with the provisions of that Section's Constitution and Bylaws. The Student Section will be represented in the KMA House of Delegates through one voting representative, a student member of the Kentucky Medical Association elected by the Student Section membership attending the University of Kentucky College of Medicine, and one voting representative, a student member of the Kentucky Medical Association elected by the Student Section membership attending the University of Louisville School of Medicine.

(g) **Service Members.** Members of the Association in good standing who enter military service and are ineligible for Associate membership shall be classified as service members. Service Members shall not be required to pay dues. If a member in good standing enters service prior to April 1 and has paid his dues for that year, he shall receive all publications and other benefits applicable to his class of membership in the Association and shall owe no further dues until January 1 following his release. If a member in good standing enters service prior to April 1 without paying his dues for that year, he shall receive publications and other benefits but shall owe the dues applicable to his class of membership immediately following his release from active duty. Members whose dues have not been received by April 1 are not in good standing.

(h) **Honorary Members.** Any physician possessed of scientific attainments who is a member of a constituent state medical association and who has participated in the program of the scientific session and who is not

a citizen of Kentucky may by unanimous vote of the House of Delegates be elected to honorary membership. Honorary members shall be entitled to the privileges of the floor in all scientific sessions.

(i) Special Members. Component societies may invite pharmacists, funeral directors, or other professional persons to become special members. Special members shall have no rights or obligations under these Bylaws, but may be accorded the privilege of attending and participating in the scientific meetings of the society, provided, however, that a registration fee may be required of special members who desire to attend the Annual Meeting of the Association.

Section 3. Hospital Medical Staff Section. There shall be a special section for hospital medical staff physicians who already hold membership in KMA. The Hospital Medical Staff Section (HMSS) shall be governed by its own Constitution and Bylaws, which Constitution and Bylaws shall not be in conflict with the Constitution, Bylaws and Board policies of the parent Kentucky Medical Association. Should any questions arise regarding the existence of a conflict, the KMA Board of Trustees shall be the final arbiter of such questions. The Hospital Medical Staff Section shall elect a Delegate and Alternate Delegate to the KMA House of Delegates. The Delegate to the KMA House of Delegates, or his Alternate as the case may be, shall be a voting member of the House and may present resolutions on behalf of the HMSS.

Section 4. Guests of Honor. Any distinguished physician not a resident of this State may become a guest of honor during any Annual Meeting upon invitation of the Board of Trustees and shall be accorded the privilege of participating in all of the scientific work of that meeting.

Section 5. No person who is finally convicted of a felony subsequent to September 26, 1968, shall be eligible for membership in this Association unless and until, upon proper application to the Judicial Council, it is determined that he is morally and ethically qualified. Except as provided in Chapter VII, Section 4 of these Bylaws, no person who is under sentence of suspension or expulsion from any component society of this Association shall be entitled to any of the rights or benefits of membership of this Association.

CHAPTER II. ANNUAL AND SPECIAL MEETINGS OF THE ASSOCIATION

Section 1. The Association shall hold its annual and special meetings at such times and places as may be determined by the House of Delegates.

Section 2. The Annual Meeting shall consist of one or more scientific sessions, at least two meetings of the House of Delegates, and such other gatherings as may be authorized by the Board of Trustees. Each scientific session shall be presided over by the President or in his absence or disability or at his request by the President-Elect or such officers as the Board of Trustees may direct. The entire time of the scientific sessions, as far as may be, shall be devoted to papers and discussions related to scientific medicine.

Section 3. The name of a physician upon the properly certified roster of members or list of delegates of a component society which has paid its annual assessment, shall be prima facie evidence of his right to register at any meeting of this Association.

Section 4. Each member in attendance at any meeting shall register indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of the society, he shall receive a badge which shall be evidence of his right to all privileges of membership at that meeting. No member or delegate shall take part in any of the proceedings of any meeting until he has complied with the provisions of this section.

CHAPTER III. THE HOUSE OF DELEGATES

Section 1. The House of Delegates shall meet in Regular Session at the time and place of the Annual Meeting, and shall, insofar as is practicable, fix its hours of meeting so as to give delegates an opportunity to attend the scientific sessions and other proceedings. Provided, however, that if the business interests of the Association and profession require, the Speaker, with the consent of the Board of Trustees, may convene the Regular Session in advance of the Annual Meeting, and the House may remain in session after the final adjournment thereof.

Section 2. The House may be called into Special Session by the President with the approval of the Board of Trustees, and a special session shall be called by the President on the written request of fifty duly elected delegates of the Association. The purpose of all special sessions shall be stated in the call, and all business transacted at any such special session shall be germane to the stated purpose.

Section 3. When a special session is called, the Secretary-Treasurer shall mail a notice of the time, place, and purpose of such meeting to the last known address of each delegate at least ten days before such session.

Section 4. The Speaker shall, by virtue of his office, be responsible for making all arrangements for all sessions, regular or special, of the House.

Section 5. The members of the House of Delegates shall be elected by the various component societies in the manner prescribed in Chapter XII of these Bylaws.

Section 6. In the event a component society is not represented at any meeting of the House, the Speaker shall consult with any officer of the component society who is in attendance and, with the approval of the Credentials Committee, may appoint any active member of such component society who is in attendance, as its alternate delegate. If no officer of such society is present, the Speaker may make the appointment without consultation, but with the approval of the Credentials Committee. All such appointments shall also be subject to the approval of the House.

Section 7. Forty percent of the qualified delegates, as defined by Article VI of the constitution, shall constitute a quorum and all of the meetings of the House shall be open to the members of the Association. The House shall have the right to go into executive session whenever in its judgment such action is indicated; except that active members of the Association shall have the right to attend all executive sessions.

Section 8. Each resolution introduced into the House shall be in writing and signed by the author and presented to the Secretary-Treasurer following its introduction. If the author presenting the resolution presents it as an individual member of the Kentucky Medical Association, the resolution shall be signed by him. If the author be a group of members or component society, the resolution shall be signed by the authorized spokesman for that group. Immediately after the resolution has been introduced, it shall be referred to the proper Reference Committee before action thereon is taken.

Section 9. No resolution shall be introduced in the first meeting of the House of Delegates by any member or group of members other than the Board of Trustees unless a copy thereof was furnished to the Headquarters Office at least seven days prior to its introduction. The only exception to this shall be that a resolution which has been signed by ten or more members of the House of Delegates and of which there are sufficient printed copies to distribute to each member of the House of Delegates may be received for consideration by an affirmative vote of three-fourths of the members present and voting. No new business shall be introduced in the last meeting of the House without unanimous consent, except when presented by the Board of Trustees. All new business so presented shall require the affirmative vote of three-fourths of those delegates present and voting, for adoption.

Section 10. The House shall give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Meeting a stepping stone to further ones of higher interest.

Section 11. It shall consider and advise as to the material interest of the profession, and of the public in those important matters wherein the public is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse information in relation thereto.

Section 12. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality and shall continue these efforts until every physician in every county of the State who will agree to abide by the constitution, bylaws and other rules and regulations of the Association and the appropriate component society, has been brought under medical society influence.

Section 13. It shall encourage postgraduate work in medical centers as well as home study and research and shall endeavor to have the results of the same utilized and intelligently discussed in the county societies.

Section 14. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Section 15. It shall, upon application, provide and issue charters to county societies organized in conformity with the Constitution and Bylaws of this Association.

Section 16. The state shall be divided into the following districts:

No. 1 — Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, McCracken, and Marshall.

No. 2 — Daviess, Hancock, Henderson, McLean, Ohio, Union, and Webster.

No. 3 — Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd, and Trigg.

No. 4 — Breckinridge, Bullitt, Grayson, Green, Hardin, Hart, Larue, Marion, Meade, Nelson, Taylor, and Washington.

No. 5 — Jefferson.

No. 6 — Adair, Allen, Barren, Butler, Cumberland, Edmonson, Logan, Metcalf, Monroe, Simpson, and Warren.

No. 7 — Anderson, Carroll, Franklin, Gallatin, Grant, Henry, Oldham, Owen, Shelby, Spencer, and Trimble.

No. 8 — Boone, Campbell, and Kenton.

No. 9 — Bath, Bourbon, Bracken, Fleming, Harrison, Mason, Nicholas, Pendleton, Scott, and Robertson.

No. 10 — Fayette, Jessamine, and Woodford.

No. 11 — Clark, Estill, Jackson, Lee, Madison, Meniffee, Montgomery, Owsley, Powell, and Wolfe.

No. 12 — Boyle, Casey, Clinton, Garrard, Lincoln, McCreary, Mercer, Pulaski, Rockcastle, Russell, and Wayne.

No. 13 — Boyd, Carter, Elliott, Greenup, Lawrence, Lewis, Morgan, and Rowan.

No. 14 — Breathitt, Floyd, Johnson, Knott, Letcher, Magoffin, Martin, Perry, and Pike.

No. 15 — Bell, Clay, Harlan, Knox, Laurel, Leslie, and Whitley.

District meetings may be held as desired, and District Medical Associations may be organized as desired, according to the districts outlined above.

Section 17. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

Section 18. It shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective, except as provided in Chapter VI, Section 4, and except for the selection of the recipient of the Kentucky Medical Association Award (Outstanding Layman) and Distinguished Service Award (Outstanding Physician), which selections shall be made by the KMA Awards Committee.

Section 19. A digest of proceedings of the House of Delegates shall be published and distributed to the membership annually.

CHAPTER IV. ELECTION OF OFFICERS AND DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Section 1. The President-Elect and the Vice President shall be elected from the state at large for a term of one year, the President-Elect succeeding to the presidency at the expiration of his term as President-Elect. A majority vote of those attending and voting shall be required for the election of the President-Elect and the Vice President and on any ballot where a majority is not obtained, the candidate with the least votes shall be dropped and further balloting held until such time as one candidate receives a majority of the votes cast. Delegates to the AMA and their alternates shall be elected from the state at large for terms of two years with the provision that no more than one delegate and no more than one alternate delegate shall be elected from one component society. The Speaker of the House of Delegates, the Vice-Speaker and the Secretary-Treasurer shall be elected for terms of three years. Trustees and their Alternates shall be elected for terms of three years and Trustees shall be limited to serving for not more than two consecutive full terms. The terms of the Trustees and their Alternates shall coincide and be so arranged that one-third of the terms expire each year, insofar as possible, provided, however, that nothing contained herein shall preclude an Alternate Trustee from serving two full terms as a Trustee. No member shall be eligible for the office of President, President-Elect, Vice-President, Secretary-Treasurer, Speaker or Vice-Speaker of the House of Delegates, Trustee or Alternate Trustee who has not been an active member of the Association for at least three years.

Section 2. During the last meeting of the regular session of the House of Delegates, the Speaker of the House of Delegates shall submit to the members of the House of Delegates a list of ten names from which, by ballot, the House of Delegates shall select five members to serve as the Nominating Committee for the next year. The five names receiving the most votes shall form the Committee, and the person receiving the most votes shall be Chairman. In the event that the Chairman so elected is unable or unwilling to serve, or in the event of a tie, the Committee shall elect one of its members as Chairman. The Committee shall meet at such time and place as determined by the Committee Chairman or the Board of Trustees, and shall schedule an open meeting immediately after the close of the first meeting of the House at each Annual Meeting. This open meeting shall be held in the meeting place of the House of Delegates, shall receive broad publicity, and those who have business to discuss with the committee shall have a hearing. The Nominating Committee shall verify the eligibility and willingness to serve of each candidate nominated. The Committee shall accept and post for information all eligible and willing candidates proposed for offices elected from the state at large. Before noon of the day following the opening meeting, the committee shall post on a bulletin board near the entrance to the hall in which the Annual Meeting is being held, its nomination, or nominations, for each office to be filled, and shall formally present said nomination, or nominations, to the House at the time of the election. Additional nominations may be made from the floor by submitting the nominations without discussion or comment. Vacancies occurring on the Nominating Committee by virtue of death, resignation, or disability, shall be filled by appointment of the Speaker.

Section 3. The election of officers and delegates to the AMA and their alternates shall be held at the second meeting of the regular session of the House of Delegates.

Section 4. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect, provided, however, that when there

are more than two nominees, the nominee receiving the least number of votes on the first ballot shall be dropped and the balloting shall continue in like manner until an election occurs.

Section 5. Any member may make known his availability for any office within the Association. However, it would be regarded as unseemly for any member to actively campaign for his own election.

Section 6. The Delegates representing the counties in each District form the Nominating Committee for the purpose of nominating a Trustee and an Alternate Trustee for the District concerned. This committee shall hold a well publicized meeting open to all active members of the District concerned who are in attendance at the Annual Meeting for the purpose of discussing the nomination of the Trustee and his Alternate to serve the District. Additional nominations may be made from the floor when the Nominating Committee makes its report to the House of Delegates.

CHAPTER V. DUTIES OF OFFICERS OTHER THAN TRUSTEES AND ALTERNATES

Section 1. Except as provided in Chapter II, Section 2 hereof, the President shall preside at all scientific sessions of the Association and shall appoint all committees not otherwise provided for. He shall deliver an annual address at such time as may be arranged and shall perform such duties as custom and parliamentary usage may require. He shall be the real head of the profession in the State during his term of office and so far as practicable, shall visit or cause to be visited on his behalf, the various sections of the State and assist the Trustees in building up the county societies and in making their work more practical and useful. He shall be reimbursed for his reasonable and necessary travel expense incurred in the performance of his duties as President.

Section 2. The President-Elect shall assist the President in visitation of county and other meetings. He shall become president of the Association at the next Annual Meeting following his election as president-elect. In the event of his death or resignation, or if he becomes permanently disqualified or disabled, his successor shall be elected by the House of Delegates and shall be installed as President of the Association at its next regular session.

Section 3. The Vice President shall assist the President in the discharge of his duties, and shall perform such other duties as may be prescribed by the Board of Trustees. In the event of a vacancy in the office of the President, the Vice-President shall succeed to the office of the President.

Section 4. The President-Elect and the Vice-President, when acting for and in behalf of the President, may be reimbursed for their reasonable and necessary travel expenses incurred in the performance of their duties in such amounts as may be available out of the sum appropriated in the annual budget for traveling expenses.

Section 5. The Speaker of the House shall preside at all meetings of the House of Delegates. He shall appoint all committees of the House of Delegates with the approval of the House of Delegates. He shall be a non-voting member of said committees, and shall perform such other duties as custom and parliamentary usage may require.

Section 6. The Vice Speaker shall assume the duties of the Speaker in his absence and shall assist the Speaker in the performance of his duties. In the event of the death, disability, resignation, or removal of the Speaker, the Vice Speaker shall automatically become Speaker of the House of Delegates.

Section 7. The Secretary-Treasurer shall advise the Executive Vice President in all administrative matters of this Association and shall act as the corporate secretary insofar as the execution of official documents or institution of official actions are required. He shall perform such duties as are placed upon him by the Constitution and Bylaws, and as may be prescribed by the Board of Trustees. The Secretary-Treasurer shall demand and receive all funds due the Association, including bequests and donations. He shall, if so directed by the House of Delegates, sell or lease any real estate belonging to the Association and execute the necessary papers and shall, subject to such direction, have the care and management of the fiscal affairs of the Association. All vouchers of the Association shall be signed by the Executive Vice President or his designee and shall be countersigned by the Secretary-Treasurer of the Association. When one or more of the above-named officials are not readily available, four specifically designated representatives of the Executive Committee are authorized to countersign the vouchers, provided that in any event all vouchers of the Association shall bear a signature and a countersignature. The four members of the Executive Committee authorized to countersign vouchers shall be designated by the Board during their reorganizational meeting in September and, whenever possible should be easily accessible from the KMA Headquarters Office. All those authorized to countersign vouchers shall be required to give bond in an amount to be determined by the Board of Trustees. The Secretary-Treasurer shall report the operations of his office annually to the House of Delegates, via the Board of Trustees, and shall truly and accurately account for all funds belonging to the Association and coming into his hands during the year. His accounts shall be audited annually by a certified public accountant appointed by the Board of Trustees.

CHAPTER VI. BOARD OF TRUSTEES

Section 1. The Board of Trustees shall be the executive body of the House of Delegates and between sessions of the House of Delegates shall exercise the powers conferred upon the House of Delegates by the Constitution and Bylaws. The Board of Trustees shall consist of the duly elected Trustees and the President, the President-Elect, the Vice-President, the immediate Past-President, the Speaker, and Vice-Speaker of the House of Delegates, the Secretary-Treasurer, and the Delegates and Alternate Delegates to the American Medical Association. The Executive Committee of the Board of Trustees shall consist of the President, the Vice-President, the President-Elect, the Secretary-Treasurer, the Chairman of the Board of Trustees, the Vice Chairman of the Board of Trustees, and two Trustees to be elected annually by the Board of Trustees. A majority of the full Board, and a majority of the full Executive Committee, to-wit, 5, shall constitute a quorum for the transaction of all business by either body. Between sessions of the Board, the Executive Committee shall exercise all the powers belonging to the Board except those powers specifically reserved by the Board to itself.

Section 2. The Board shall meet daily, or as required, during the Annual Meeting of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of three Trustees. It shall meet on the last day of the Annual Meeting for reorganization and for the outlining of the work for the ensuing year. It shall, through its Chairman, make an annual report to the House of Delegates at such time as may be provided, which report shall include an audit of the accounts of the Secretary-Treasurer and other agents of this Association and which shall also specify the character and cost of all the publications of the Association during the year, and the amounts of all other property belonging to the Association, or under its control, with such suggestions as it may deem necessary. By accepting or rejecting this report, the House may approve or disapprove the action of the Board of Trustees in whole or in part, with respect to any matter reported upon therein. In the event of a vacancy in any office other than that of President, the Board may fill the same until the annual election.

Section 3. Each Trustee shall be organizer, peacemaker and censor for his district. He shall hold at least one district meeting each year for the exchange of views on problems relating to organized medicine and for post-graduate scientific study. The necessary traveling expenses incurred by a Trustee in the line of his duties herein imposed may be paid by the Secretary-Treasurer upon a proper itemized statement but this shall not be constituted to include his expenses in attending the Annual Meeting of the Association.

Section 4. The Board shall have the authority to communicate the views of the profession and of the Association in regard to health, sanitation, and other important matters, to the public and press.

Section 5. The *Journal of the Kentucky Medical Association* shall be the official organ of the Association and shall be published under the supervision of the Board. The Editor of the *Journal* shall be elected by the Board. All money received by the *Journal* or by any member of its staff on its behalf, shall be paid to the Secretary-Treasurer on the first of each month. The Board shall provide for and superintend the publication and distribution of all proceedings, transactions, and memoirs of the Association, and shall have authority to appoint such assistants to the Editor as it deems necessary.

Section 6. All commercial exhibits during the Annual Meeting shall be within the control and direction of the Board.

Section 7. In the event of the death, resignation, removal or disability of a Trustee, between sessions of the House of Delegates, the Alternate Trustee shall succeed to the office of Trustee. In the case of disability, the Alternate shall serve until the disability is removed or the Trustee's term expires, and in the absence of the Trustee, the Alternate Trustee shall vote in his place and stand.

Section 8. The Association, upon the request of any member in good standing who is a defendant in a professional liability suit, will provide such member with the consultative service of competent legal counsel selected by the Secretary-Treasurer acting under the general direction of the Executive Committee. In addition, the Association may, upon application to the Board outlining unusual circumstances justifying such action, provide such member with the services of an attorney selected by the Board to defend such suit through one court.

Section 9. The Board shall employ an Executive Vice President whose principal duty shall be to carry out and execute the policies established by the House of Delegates and the Board. His compensation shall be fixed by the Board. The Executive Vice President shall act as general administrative officer and business manager of the Association and shall perform all administrative duties necessary and proper to the general management of the Headquarters Office, except those duties which are specifically imposed by the Constitution and Bylaws upon the officers, committees, councils and other representatives of the Association. He shall refer to the various elected officials all administrative questions which are properly within their jurisdiction.

He shall attend the Annual Meeting, the meetings of the House of Delegates, the meetings of the Board, as many of the committee and council meetings as possible, and shall keep separately the records of their respective

proceedings. He shall, at all times, hold himself in readiness to advise and aid, so far as is possible and practicable, all officers, committees, and councils of the Association in the performance of their duties and in the furtherance of the purposes of the Association. He shall be allowed traveling expenses to the extent approved by the Board.

He shall be the custodian of the general papers and records of the Association (including those of the Secretary-Treasurer) and shall conduct the official correspondence of the Association. He shall notify all members of meetings, officers of their election, and committees and councils of their appointment and duties.

He shall account for and promptly turn over to the Secretary-Treasurer all funds of the Association which come into his hands. It shall be his duty to receive all bills against the Association, to investigate their fairness and correctness, to prepare vouchers covering the same, and to forward them to the Secretary-Treasurer for appropriate action. He shall keep an account with the component societies of the amounts of their assessments, collect the same, and promptly turn over the proceeds to the Secretary-Treasurer. He shall, within thirty days preceding each Annual Meeting, submit his financial books and records to a certified public accountant, approved by the Board, whose report shall be submitted to the House of Delegates.

He shall keep a record of all physicians in the State by counties, noting on each his status in relation to his county society, and upon request shall transmit a copy of this list to the American Medical Association.

He shall act as Managing Editor, or otherwise supervise the publication of *The Journal of the Kentucky Medical Association* and such other publications as may be authorized by the House of Delegates, under the guidance and direction of the Board.

He shall perform such additional duties as may be required by the House of Delegates, the Board, or the President, and shall employ such assistants as the Board may direct. He shall serve at the pleasure of the Board, and in the event of his death, resignation, or removal, the Board shall have the power to fill the vacancy. From time to time, or as directed by the Board, he shall make written reports to the Board and House of Delegates concerning his activities and those of the Headquarters Office.

CHAPTER VII. DISCIPLINE — THE JUDICIAL COUNCIL

Section 1. There is hereby created a Judicial Council composed of the Secretary-Treasurer of the Association and four members to be elected by the House of Delegates for terms of four years each. One member shall be elected from each of the traditional eastern, western, and central districts, and one member from the state at large. Members of the first Judicial Council shall be elected for terms of one, two, three, and four years, respectively so that hereafter, one member will be elected each year. The Council shall annually elect a chairman.

To be eligible for membership on the Judicial Council, a nominee shall possess at least one of the following qualifications: (1) Have served one term as an officer, trustee, or a Delegate to the AMA or (2) Have served five years as a member of the House of Delegates.

It shall be the duty of the Board of Trustees to nominate at least one candidate for each vacancy on the Judicial Council, but additional nominations may be made from the floor. Vacancies which occur between Regular Sessions of the House of Delegates, shall be filled by the Board of Trustees. No member, other than the Secretary-Treasurer shall serve more than two consecutive terms.

Section 2. The Judicial Council shall be the Board of Censors of the Association. It shall be the final arbiter of all questions involving the right and standing of members, whether in relation to other members, to the component societies, or to this Association. All charges of breach of medical ethics brought before the House of Delegates shall be referred to the Judicial Council without discussion. A member who has been convicted of a felony or of any violation of the Medical Practice Act, or who violates any of the provisions of the constitution, bylaws, or any rule or regulation of this Association, or the Principles of Ethics of the American Medical Association shall be liable to censure, fine, suspension, or expulsion upon order of the Judicial Council. Provided, however, that if in addition to discipline by the Association, the Judicial Council shall be of the opinion that the offending member's license to practice medicine shall be revoked, it shall report this to the Board of Trustees as a recommendation that the Board refer the matter to the State Board of Medical Licensure for this purpose.

Suspension shall be for a specified period during which the member shall remain liable for the payment of dues but shall not be eligible to hold office, attend business meetings or otherwise participate in Associational activities at the county, district or state levels. Upon the expiration of the period of suspension, every suspended member shall be automatically restored to all of the rights and privileges of his class of membership unless the Judicial Council determines that his conduct during the period of suspension indicates that he is unworthy of such restoration, in which event his suspension may be extended or he may be expelled.

Upon the complaint of any member or aggrieved individual involved, the

Judicial Council may initiate disciplinary proceedings against any member, and may intervene in or supersede county, individual trustee, or district disciplinary proceedings, whenever in its sole judgment and opinion, a disciplinary matter is not being handled in an expeditious manner, and may render a decision therein. In all cases in which the Association, rather than a member or aggrieved individual, appears to be the real party in interest, the Judicial Council may refer the complaint to the Board of Trustees for a determination as to whether probable cause for disciplinary action exists. If the Board of Trustees resolves this question in the affirmative, it shall so charge the respondent, and a representative of the Board shall thereupon be responsible for presenting the evidence in support of such charge at any hearing held thereon.

In all proceedings of the Judicial Council, the due process requirements of reasonable notice and a full and fair hearing shall be observed. No recommended disciplinary decision of an individual trustee or any district grievance committee shall become effective unless and until approved by the Judicial Council.

Section 3. It shall consider all appeals from the recommended decisions of individual trustees and District Grievance Committees. In this case of appeals from the decisions of individual trustees, the Judicial Council may admit such oral or written evidence as in its judgment will best and most fairly present the facts, but all appeals from the recommended decisions of District Grievance Committees shall be considered on the record made before such committee. It shall be the duty of the Secretary to notify the parties with respect to its disposition of each case.

Section 4. The Judicial Council may hear appeals from the disciplinary orders of component societies. Provided, however, that such appeals shall be considered on the record made before the component societies.

Section 5. Efforts toward conciliation and compromise shall precede the hearing of all disciplinary cases, but the decision of the Judicial Council shall be final. A party aggrieved by the decision of the Judicial Council may seek an appeal to the Judicial Council of the American Medical Association in accordance with the jurisdiction, rules and regulations of that Association.

Section 6. Component societies are encouraged to create suitable disciplinary procedures which guarantee due process, and to dispose of all disciplinary problems which come to their attention. It is recognized, however, that it may not be feasible for some societies to do so, and the District Grievance Committees hereinafter created, are designed to meet the needs of county societies which are without a functioning grievance committee.

Section 7. The trustee of each district is hereby designated the chairman of his District Grievance Committee. The Judicial Council shall designate two additional trustees from districts adjoining that of the chairman, and the three trustees thus selected shall constitute the District Grievance Committee. All grievances which cannot be resolved by individual trustees, shall be referred to the local grievance committee or the district grievance committee for the district in which the respondent physician or county society resides.

Section 8. District Grievance Committees shall investigate every grievance coming to their attention, taking care that the physician complained of shall have ample opportunity to respond to the complaint. If, after careful investigation the complaint appears to be without merit, the committee shall so report to the Judicial Council, including sufficient facts in its report to enable Judicial Council to form its own conclusions.

If the District Grievance Committee's investigation indicates that the member may be a proper subject of disciplinary action, the committee shall, upon reasonable notice, hold a hearing at which the complainant and the respondent shall be entitled to be represented by counsel, to present the testimony of witnesses in his behalf, and to cross-examine witnesses against him. All testimony shall be under oath and shall be recorded by a competent reporter at the expense of the Association, but shall not be transcribed unless and until an appeal is taken as hereinafter provided.

When all of the testimony has been heard and all evidence received, the committee shall make written findings and recommendations which it shall transmit to the Judicial Council, furnishing copies thereof to the parties.

Section 9. Any party aggrieved by the findings or recommendations of the committee, may, within 30 days, appeal to the Judicial Council. Appeals shall be taken by filing with the Secretary-Treasurer a copy of the entire record made before the District Grievance Committee (including a transcript of the testimony, procured at the appellant's expense) together with a written statement of appeal pointing out in detail wherein the committee has erred, and directing the attention of the Judicial Council to those portions of the transcript upon which he relies, provided, however, that the Judicial Council may extend the time in which the transcript must be filed, upon request made within the initial thirty-day period.

Section 10. No report or opinion of the Judicial Council shall be considered the policy of the Association until approved by the House of Delegates. Any report or opinion of the Judicial Council submitted to the House of

Delegates may be accepted or rejected or referred back to the Judicial Council but not modified by the House of Delegates.

CHAPTER VIII. COMMITTEES AND COMMISSIONS

Section 1. The Board of Trustees shall have authority from time to time to appoint, fix the duties of, and abolish such standing committees and commissions as it deems necessary or desirable to assist it in carrying on the Association's activities in the fields of business and scientific meetings, medical education and hospitals, legislation, medical services, communications and public service, and governmental medical services.

Section 2. The Executive Committee shall serve as the nominating committee for all standing committee and commission appointments, but the trustees may make additional nominations. When the Executive Committee sits as such nominating committee, the President-Elect shall serve as Chairman.

Section 3. The President, with the advice and consent of the Chairman of the Board of Trustees, may appoint temporary ad hoc committees to perform specified functions. All such committees shall expire at the end of the term of the President by whom appointed.

Section 4. No committee or commission shall have power or authority to fix or determine Associational policy or to commit the Association to any course of action, such powers being expressly reserved to the House of Delegates and the Board of Trustees.

CHAPTER IX. ASSESSMENTS AND EXPENDITURES

Section 1. The annual dues for membership in this Association shall be as follows: (1) Active Member, \$400, (except (a) those physicians elected to KMA membership within six months of the completion of their residency, fellowship or fulfillment of government-obligated service shall pay only one-half of the full active member rate their first full year of membership; (b) those physicians in their second year of practice shall pay only three-fourths of the full active member rate for their second full year of membership; and (c) those physicians who have reached the age of 70 and work 20 hours or less per week shall pay only one-half of the full active member rate per year for their KMA membership); (2) Life Members, no dues; (3) Associate Members, \$75; (4) In-training Members, \$30, except that in-training members shall not be liable for dues during the first six months of their first postgraduate year in an approved residency program in Kentucky; (5) Inactive Members, \$80; (6) Students Members, no dues; (7) Service Members, no dues; (8) Special Members, no dues. The dues during the first year for any active member shall be prorated on a quarterly basis as determined by the date of his application. Dues fixed by these Bylaws shall constitute assessments against the component societies. Unless otherwise instructed by the Board of Trustees (which may institute centralized billing) the Secretary of each component society shall forward its assessments, together with its properly classified roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county, to the Secretary-Treasurer of this Association as of the first day of January each year.

Section 2. Unless otherwise provided by the Board of Trustees pursuant to Section 1 hereof, any component society which fails to pay its assessments, or make the report as required, on or before the first day of April in each year, shall be held as suspended and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Section 3. All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have prior approval of the Board of Trustees before they can become effective. No motion or resolution, the adoption of which would require a substantial expenditure of funds, shall be considered by the House of Delegates unless the funds have been budgeted or are provided by the motion or resolution.

CHAPTER X. RULES OF CONDUCT

The principles set forth in the Principles of Ethics of the American Medical Association, together with the Constitution and Bylaws of the Association and all duly adopted resolutions of the House of Delegates, shall govern the conduct of members in their relation to each other and to the public.

CHAPTER XI. RULES OF ORDER

The deliberations of this Association shall be governed by parliamentary usage as contained in the latest edition of Davis's *Rules of Order*, unless otherwise determined by a vote of its respective bodies.

CHAPTER XII. COUNTY SOCIETIES

Section 1. Except as provided in Section 3 of this Chapter, all county medical societies in this State which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the House of Delegates, receive a charter from and become a component part of this Association.

The House of Delegates shall have authority to evoke the charter of any component society whose actions are in conflict with the letter or spirit

of the Constitution and Bylaws.

Section 2. As rapidly as can be done after the adoption of this Constitution and Bylaws, a medical society shall be organized in every county in the state in which no component society exists, and charters shall be issued thereto.

Section 3. Only one component society shall be chartered in any county. Membership in the component society thus created shall entitle the members thereof to all the rights and benefits of membership in the Kentucky Medical Association.

Section 4. In sparsely settled sections two or more component societies may join for scientific programs, the election of officers, and such other matters as they may deem advisable. The component societies thus combined shall not lose any of their privileges or representation. The active members of each component society shall annually elect at least a Secretary and a Delegate for the transaction of its business with the Association.

Two or more adjacent component societies may also combine into one multi-county component society by adopting resolutions to that effect at special meetings called for that purpose on at least ten days' notice. Copies of the resolution, certified as to their adoption by the Secretary of each society, shall be forwarded to the Headquarters Office. If approved by the Board of Trustees, the multi-county society shall thereupon be issued a charter, the consolidating county societies shall cease to exist and the multi-county society shall become a component society of this Association; provided, however, that the active members residing in each county comprising the multi-county society shall be entitled to elect a delegate or delegates to the House of Delegates, as if each such county constituted a component society within the meaning of Section 11 of this Chapter; and provided, further, that multi-county societies may elect, at large, one alternate delegate for each delegate to which it is entitled under this section and such alternate may serve in the absence of the delegate for whom he is the designated alternate.

A multi-county component society may be disaggregated so that an individual county society may regain independent status when a majority of the members in that county indicate their desire to reorganize. At that time the members from the withdrawing county shall forward a petition containing the signatures of a majority of the members in that county to be validated by KMA. The withdrawing county shall further forward a resolution to the KMA Headquarters Office to be submitted to the House of Delegates at its next regular meeting, requesting recognition as a county society and issuance of a charter, in accord with Chapter XII, Section 1 of the KMA Bylaws. Once this charter is issued, the new county society shall become a recognized entity at the beginning of the following KMA dues year and those counties remaining with the original multi-county unit may continue to function under their pre-existing charter.

Section 5. Each component society shall be the sole judge of the qualifications of its own members. All members of component societies shall be members of the Kentucky Medical Association and shall be classified in accordance with Chapter I, Section 2 of these Bylaws, provided, however, that no physician who is under suspension or who has been expelled shall thereafter, without reinstatement by the Board of Trustees be eligible for membership in any component society. Any physician who desires to become a member of the Kentucky Medical Association shall first apply to the component society in the county in which he resides, for membership therein. Except as hereinafter provided in Sections 6 and/or 8 of this chapter, no physician shall be an active member of a component society in any county other than the county in which he resides.

Section 6. Any physician who may feel aggrieved by the action of the component society of the county in which he resides, in refusing him membership, shall have the right to appeal to the Board of Trustees, which, upon a majority vote, may permit him to apply for membership in a component society in a county which is adjacent to the county in which he resides.

Section 7. When a member in good standing in a component society moves to another county in the State, his name, upon request, shall be transferred without cost to the roster of the component society into whose jurisdiction he moves, if he is admitted to membership therein.

Section 8. A physician whose residence is closer to the headquarters of an adjacent component society than it is to the headquarters of the component society of the county in which he resides, may, with the consent of the component society within whose jurisdiction he resides, hold membership in said adjacent component society.

Section 9. Each component society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Upon reasonable notice and after a hearing, component societies may discipline their members by censure, fine, suspension or expulsion, for any breach of the Principles of Medical Ethics or any bylaw, rule or regulation lawfully adopted by such societies or this Association. At every hearing, the

accused shall be entitled to be represented by counsel and to cross-examine witnesses, and the society shall cause a stenographic record to be made of the entire proceedings. The stenographer's notes need not be transcribed unless and until requested by the respondent member.

Any physician aggrieved by the disciplinary action of a component society may, within ninety (90) days, appeal to the Judicial Council, whose decision shall be final. This appeal shall be in writing and shall point out in detail the errors committed by the county society. It shall be accompanied by a transcript of the proceedings before the county society, procured at appellant's expense, and the statement of appeal shall direct the attention of the Judicial Council to those portions of the transcript upon which he relies.

Any member who fails or refuses to comply with the lawful disciplinary orders of his component society shall, if such failure or refusal continues for more than thirty (30) days, be automatically suspended from membership, provided, however, that an appeal shall stay the suspension until a final decision is made by the Judicial Council.

The resignation of a member against whom disciplinary charges are pending or who is in default of the disciplinary judgment of his county society, a district grievance committee or the Board of Trustees shall not be accepted and no member who is suspended or expelled may be reinstated or readmitted unless and until he complies with all lawful orders of his component society and the Board of Trustees.

Section 10. Frequent meetings shall be encouraged and the most attractive programs arranged that are possible. Members shall be especially encouraged to do postgraduate and original research work, and to give the society the first benefit of such labors. Official positions and other references shall be unstintingly given to such members.

Section 11. At the time of the annual election of officers, each component society shall elect a delegate or delegates to represent it in the House of Delegates. The term of a delegate shall commence on the first day of the regular session of the House following his election, and shall end on the day before the first day of the next regular session, provided, however, that component societies may elect delegates for more than one term at any election. Each component society may elect one delegate for each 25 voting members in good standing, plus one delegate for one or more voting members in excess of multiples of 25, provided, however that each component society shall be entitled to at least one delegate regardless of the number of voting members it may have and that each multi-county society shall be entitled to the same number of delegates as its component societies would have had. The secretary of the society shall send a list of such delegates to the Secretary-Treasurer of this Association not later than 45 days before the next Annual Meeting. It shall be the obligation of a component society which elects delegates to serve more than one year, to provide the KMA Headquarters Office with a certified list of its delegates each year.

Section 12. The secretary of each component society shall keep a roster of its members and a list of nonaffiliated licensed physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information upon blanks supplied him for the purpose, to the Secretary-Treasurer of the Association, on the first day of January of each year or as soon thereafter as possible, and at the same time the dues accruing from the annual assessment are sent in. In keeping such roster the secretary shall note any change in the personnel of the profession by death or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

CHAPTER XIII. AMENDMENTS

Section 1. These bylaws may be amended at any session of the House of Delegates by a majority vote of the Delegates present at a meeting of that session, provided: (1) the amendment proposed is presented in writing to the Delegates thirty days prior to the meeting, or (2) the amendment is introduced in writing at a regular meeting of the House of Delegates during the session and considered at the following meeting of the session, the vote on said amendment having been postponed definitely for a period of at least one day.

Section 2. An amendment to or change in the bylaws may be proposed by a reference committee or by the Board of Trustees at the final meeting of a session of the House of Delegates but, not having been postponed definitely for a period of one day, requires a two-thirds vote.

Section 3. An amendment to these bylaws may be proposed in writing by an individual Delegate at the final meeting of a session of the House of Delegates. If such an amendment is proposed, the proposal will be postponed definitely and studied by the appropriate reference committee at that time, reporting their recommendation back to the House of Delegates before the final meeting is adjourned. Such an amendment, having not been postponed definitely for a period of one day, requires a two-thirds vote.

1992-93 KMA Committees

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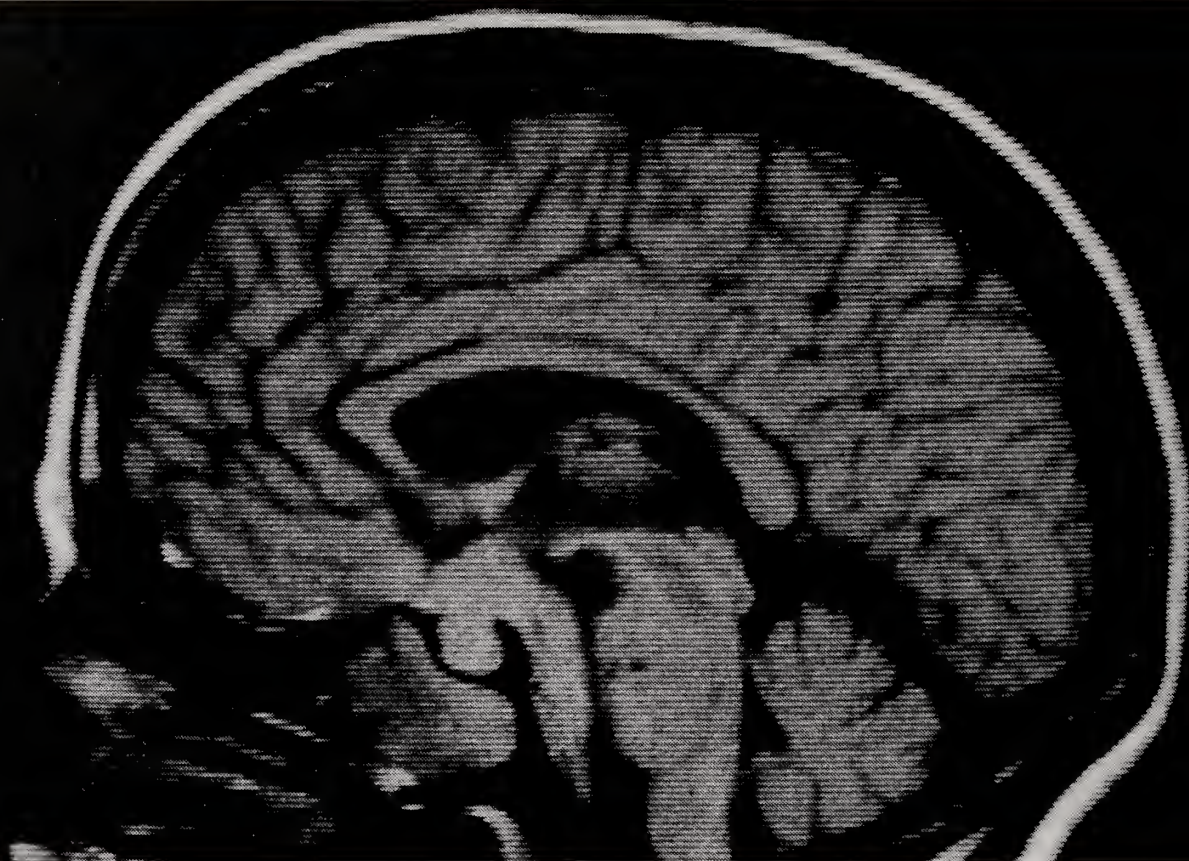
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Through its Committee on Impaired Physicians, KMA helps doctors who are suffering from alcoholism and drug addiction. The thrust of the program is rehabilitative, not punitive. The Committee is composed of physicians who have special expertise in these areas, some from personal experience. Effective treatment for these illnesses is achieved most easily when the disease is detected early; family, friends, and associates are urged to avoid misguided sympathy which enables the condition to deteriorate.

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in the Kentucky General Assembly from 1977 to 1990 —*



JOHN L. TREVEY
1933 - 1990

COVER — Pioneer physician Ephraim McDowell stands in the rotunda of the state capitol amid some of Kentucky's most prestigious sons. President Abraham Lincoln stands in the center, surrounded by McDowell (monument in the background); Senator Henry Clay, Kentucky's most famous statesman; Jefferson Davis, President of the Confederacy during the Civil War; and Alben Barkley, US Vice President.

JAN 23 1992

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FOREWORD

The 1992 Kentucky General Assembly convened on January 7. The KMA Quick Action Committee, along with the State Legislative Committee Chairman, will be meeting in Frankfort on a weekly basis to establish positions on various legislative proposals and direct the overall effort. Full-time lobbyists are on duty in Frankfort to represent physicians and are available to respond to your inquiries upon request. The Frankfort Office will be coordinating activities between the Capitol and the KMA Headquarters Office. Members of the KMA staff in Louisville will be involved daily communicating with members, legislative staff, and carrying out day-to-day activities in conjunction with the legislative effort.

However, the major lobbying effort must rest with the 138 KMA Key Contacts and physician constituents of the 138 members of the Kentucky General Assembly. The most important contribution you can make is to take the time to write a personal letter to your legislator outlining your personal concerns, particularly as they relate to your patients. Follow up that letter with a phone call. Then urge your fellow physicians to do the same.

If you have questions during the Session, don't hesitate to contact your Trustee, KMA Officers, or staff. We are interested in your views and need your full support during these difficult months.

KMA Headquarters Office: (502) 426-6200

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The Kentucky Medical Association gratefully acknowledges the Legislative Research Commission, Vic Hellard, Jr, Director, for its cooperation in providing photographs and some of the information for this publication.

EFFECTIVE LEGISLATIVE CONTACTS



HOW TO CONTACT YOUR LEGISLATOR

Try to establish a relationship with your own Senator and Representative. In general, you'll have more influence as a constituent.

Contacting your legislator, whether in writing, by phone, or in person, need not be difficult or frightening. The following information is provided to assist you in making legislative contacts and communicating effectively.

Your legislators can generally be reached at home on weekends and in Frankfort on weekdays while the Kentucky General Assembly is in session. (Refer to the "Legislative Calendar" provided in this publication). Local addresses and phone numbers of Kentucky legislators are noted on the "Roster of Kentucky General Assembly Members," which is also a part of this publication.

When the General Assembly is in session, you may call your legislator in Frankfort at the **Legislative Offices number . . . (502) 564-8100**, or call the **Legislative Message Center WATS Line . . . 1-800-372-7181**, and leave a message for him. You may also check the status of a bill by calling the toll-free **Bill Status WATS Line . . . 1-800-382-2455**. A toll-free **Calendar Line . . . 1-800-633-9650**, is available where you may hear a taped calendar of committee meetings and the schedule for the Chambers to be in session. The calendar is updated daily.

Correspondence to your legislator while he or she is in Frankfort should be addressed as follows:

The Honorable John Smith
The Kentucky Senate (or Kentucky House
of Representatives
State Capitol
Frankfort, KY 40601

Dear Senator Smith: or
Dear Representative Smith:

If you are discussing a piece of legislation which has already been introduced, be sure to identify the bill by its number and subject. State legislation is labeled **Senate Bill ____ (SB)**; **House Bill ____ (HB)**. Some legislation is introduced in the form of a resolution in the Senate or House of Representatives or both, and is labeled **Senate Resolution ____ (SR)**; **House Resolution ____ (HR)**. If discussing a matter that has not yet been introduced, **be sure to properly and thoroughly identify the subject matter.**

If you have any questions or need assistance, contact the KMA office at 301 N Hurstbourne Pky, Suite 200, Louisville, KY 40222, phone: (502) 426-6200.

To assist KMA in coordinating its legislative effort, **please send copies of your correspondence and any response to the State Legislative Activities Department of KMA; also**



send a brief note about personal or phone contacts and results.

The KMA encourages members and spouses to visit Frankfort during the Session. Before you go, call your Legislator and arrange for a personal visit. Legislators' schedules are extremely hectic, and it is **vital that you be on time for your appointment**. Also, don't overstay your visit; others have similar appointments. If you are planning to go to Frankfort, contact the KMA Headquarters Office, and a briefing by KMA lobbyists can be arranged prior to your visit with the Legislator.

A PRESCRIPTION FOR RESULTS IN THE LAWMAKING PROCESS

Do know the proper way to address a member of the legislature. In written correspondence, members of the House and Senate should be referred to as The Honorable John Smith and the letter should begin either Dear Senator Smith or Dear Representative Smith, whichever the case may be.

Don't expect results from form letters. This is the least personal, least effective way to communicate with an elected official. Most mailings of this type are filed away — usually in the trash.

Do ask for an appointment when you want a personal visit. Most members of the Kentucky General Assembly try to balance their time. They are more than willing to meet with constituents, but appreciate the courtesy of scheduling an appointment in advance.

Don't overstay your welcome. If you say you need 15 minutes, then speak your piece, check the clock and be on your way. Meetings of a complicated nature often require more time. Should this be the case, then make sure the legislator knows before the meeting starts, not after.

Do get straight to the point of the meeting. State your case

clearly and concisely, and be prepared to respond to any questions the legislator may have.

Don't bring volumes of written material with you. Unless the subject is extremely complex, a brief written summary, folder or fact sheet is preferable and more likely to be read.

Do know your subject matter inside out. If you are going to be a spokesperson for an issue or a cause, then you should be prepared to not only define it, but explain and defend it as well.

Don't be the source of inaccurate or misleading information. There is no substitute for truthfulness and candor in dealing with elected officials. Most of them abide by the old maxim, "Lie to me once, shame on you; lie to me twice, shame on me."

Do volunteer to provide additional data about the subject matter. When your cause or issue comes up, you want the legislator to think of you. Legislators want to be well-versed on all sides of your issue. The opportunity to provide continuing support material is not only in your best interest, but their best interest as well.



EIGHT MAJOR MISTAKES IN DEALING WITH LEGISLATORS

1. Assume each legislator is a walking encyclopedia on every pending issue.

During a normal session of the General Assembly, approximately 1500 different bills are introduced with about one third becoming law. That's a lot of legislation to read, review and remember. It's virtually impossible for every legislator to know every bill, chapter and verse. Individual legislators are most familiar with three types of bills — those they personally sponsor, those that come before committees on which they serve, and those that someone in their district has urged them to either support or oppose.

2. Expect a commitment on the spot.

Most legislators are thoughtful, deliberate types, who make a point to seek out all sides of a particular issue before taking a position. Remember that a good politician generally checks out the water's depth before diving.

3. Come armed without the facts.

Smoke and mirrors won't do the job in winning a legislator over. You must demonstrate through tangible evidence supported by facts that a particular action is both desirable and justifiable — and the ultimate burden of proof is on you.

4. Forget there's always another side to the issue.

Each state representative has an average of 37,280 constituents; each state senator has an average of 98,105. You can be sure that there's at least one constituent, if not more, who has a different position on an issue and, just like you, expects to have his or her voice heard. As one veteran officeholder is fond of saying, "Some of my friends are for this bill, some are against — and I'm sticking with my friends!"

5. Run down the opposition.

Name-calling or derogatory remarks don't win friends and influence legislation. If your issue can't stand on its own merit, then your cause is already lost. Besides, your legislator's brother-in-law might be a key member of the group that's on the other side of the fence!

6. Burn your bridges when you don't win.

Working with the legislators is an investment that may not pay off immediately. Don't burn your bridges if results aren't immediately forthcoming.

7. Fail to say thank you.

Even though meeting with constituents comes with the territory for legislators, it's still an act that should be acknowledged. A thank-you note for taking the time to meet with you is always in order.

8. Leave never to be heard from again.

One phone call or visit isn't enough. That means keeping in touch to let the legislator know that your interest is not a passing fancy. Stay on top of developments relating to your issue so that when new and relevant information becomes available, you can pass it along.

KENTUCKY AND ITS GENERAL ASSEMBLY

DID YOU KNOW . . . ?

Kentucky is a Commonwealth

The two designations “commonwealth” and “state” were synonymous when Kentucky joined the Union in 1792. Of the four commonwealths in the United States, Massachusetts, Pennsylvania and Virginia were originally British colonies. Kentucky was once a part of Virginia, and at the time of their separation it chose to call itself the Commonwealth of Kentucky.

Kentucky's Capitol

Kentucky's Capitol, surrounded by 34 acres of landscaped grounds — flower gardens, neatly trimmed shrubs and tree-lined sidewalks — was officially dedicated on June 1, 1910, and is still one of the most handsome statehouses in America.

Government

Kentucky's Constitution provides for three branches of state government — the legislative, to enact laws; the judicial, to interpret them; and the executive, to enforce them.

Offices of the executive, judicial and legislative branches of state government are housed in Kentucky's Capitol. The building is open every day, with free guided tours from 8 AM to 4:30 PM, Monday through Friday, and 8:30 AM to 4:00 PM on Saturdays, 1 PM to 4:30 PM Sundays, and 8 AM to 4:30 PM on most holidays. The tours visit the State Reception Room, the Supreme Court, the Senate and the House of Representatives.

Executive Branch

The governor is chief executive of the Commonwealth. He is elected for a four-year term, together with the lieutenant governor, secretary of state, attorney general, state treasurer, commissioner of agriculture, superintendent of public instruction, auditor of public accounts and the three members of the railroad commission.

The executive branch is divided into cabinets, each of which is headed by an appointed official called a secretary. The secretaries form the governor's cabinet and advise the chief executive upon many of his decisions concerning the administration of state government.

In addition, the executive branch consists of various independent agencies and regulatory commissions carrying out particular functions by law. Enforcement of the law not only involves insisting the law is obeyed, but also consists of many duties necessary in carrying out the law's provisions — most of which involve services to citizens of the Commonwealth.

Judicial Branch

Courts of the state interpret the laws, settle controversies between individuals and apply criminal sanctions. Kentucky greatly altered its court system when voters approved the Judicial Article in 1975 amending the state constitution. Part of the amendment took effect in January, 1976; other sections went into effect in January, 1978.

The new court system is based on a four-tiered structure of district courts, circuit courts, a 14-member Court of Appeals, and a seven-member Supreme Court.

District courts are courts of limited jurisdiction and serve judicial districts of one or more counties. Circuit courts have original and appellate jurisdiction as may be provided by law.

The Court of Appeals is divided into separate panels which have appellate jurisdiction. In addition, it may be authorized by the Supreme Court to review administrative agency decisions.

The Supreme Court hears lower-court appeals and assumes budgetary and administrative responsibility for the entire system.

Legislative Branch

Kentucky's General Assembly has two chambers — the Senate and the House of Representatives. One hundred representatives are chosen for two-year terms; 38 senators are elected for four-year terms. Every two years, all the representatives and one-half of the senators are elected. The General Assembly meets in regular session in January of even-numbered years. Regular sessions are limited to 60 legislative days. The governor may call the legislators into special session to consider matters specified by him. The General Assembly has the power to enact all laws — subject to the constitutional limitations. Proposed laws may be introduced in either chamber, but the House of Representatives must originate revenue-raising measures.

During the 59-day period, well over 1500 pieces of legislation will be considered, of which approximately 10% will be health related.

THE LAWMAKING PROCESS

NEW laws aren't born overnight. First, the necessity or idea for a law must be established. Once an idea has been formulated, it is then drafted into bill form. Bill drafts come from any number of sources, but only a legislator can sponsor a bill and file it for consideration by the full assembly.

Bills can be introduced in one house or in both simultaneously — except for appropriations bills, which must originate in the House. But even identical bills must travel through each chamber.

Once introduced, a bill is read by title and number and referred to the committee having jurisdiction over the subject. The committee discusses the bill and makes a recommendation. Some pieces of legislation "die" in committee and never reach the floor. But if the bill is reported from the committee, it is put on the calendar for reading — three times, once per day. After it is read for the third time, the bill is voted on. A bill that receives a majority of the votes cast (with at least two-fifths of the membership present) is

passed on to the other chamber, where it undergoes the same procedure.

There are four types of legislation that require more than a simple majority for passage. Appropriations bills, the call for a constitutional convention and emergency bills (those which take effect immediately) require a favorable vote of the majority of all elected members. This is called a constitutional majority. Amendments to the state constitution must receive a favorable nod from three-fifths of the membership.

Once approved by both chambers, the bill has one more hurdle to overcome. It must be acted upon by the governor. The governor has three options: to sign the bill into law, veto the bill, or allow it to become law without his signature.

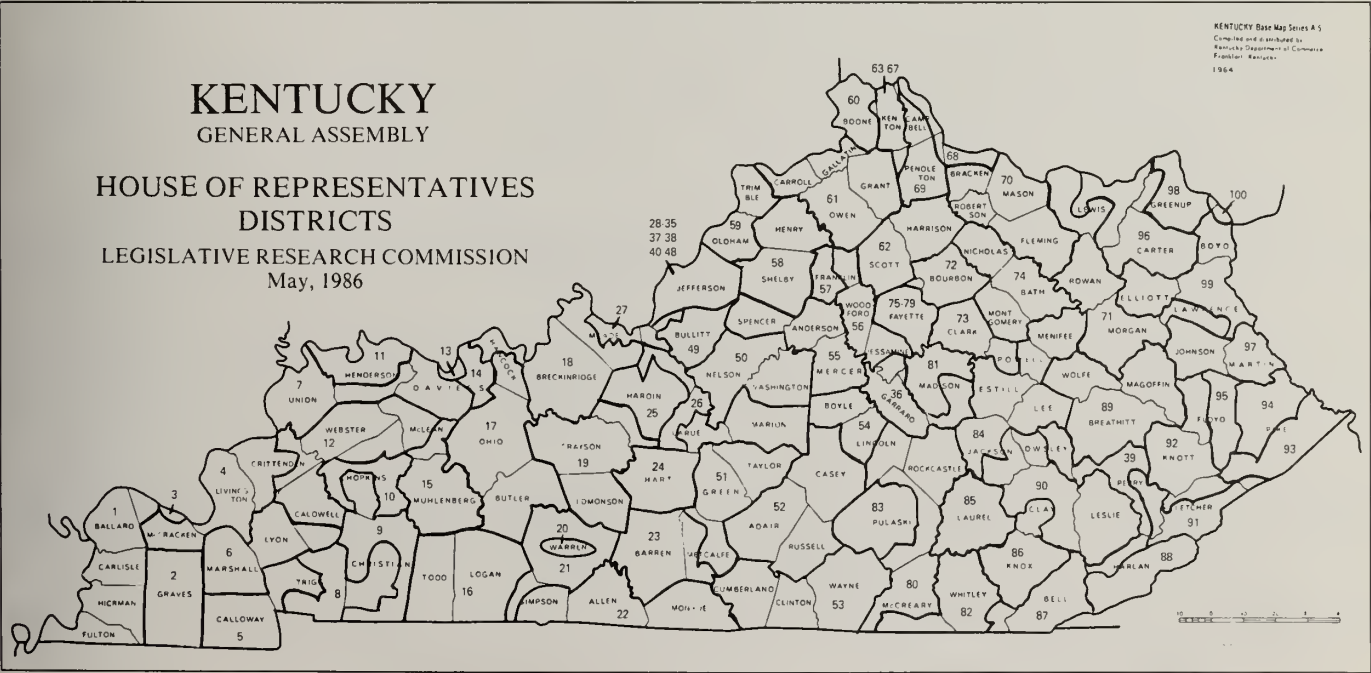
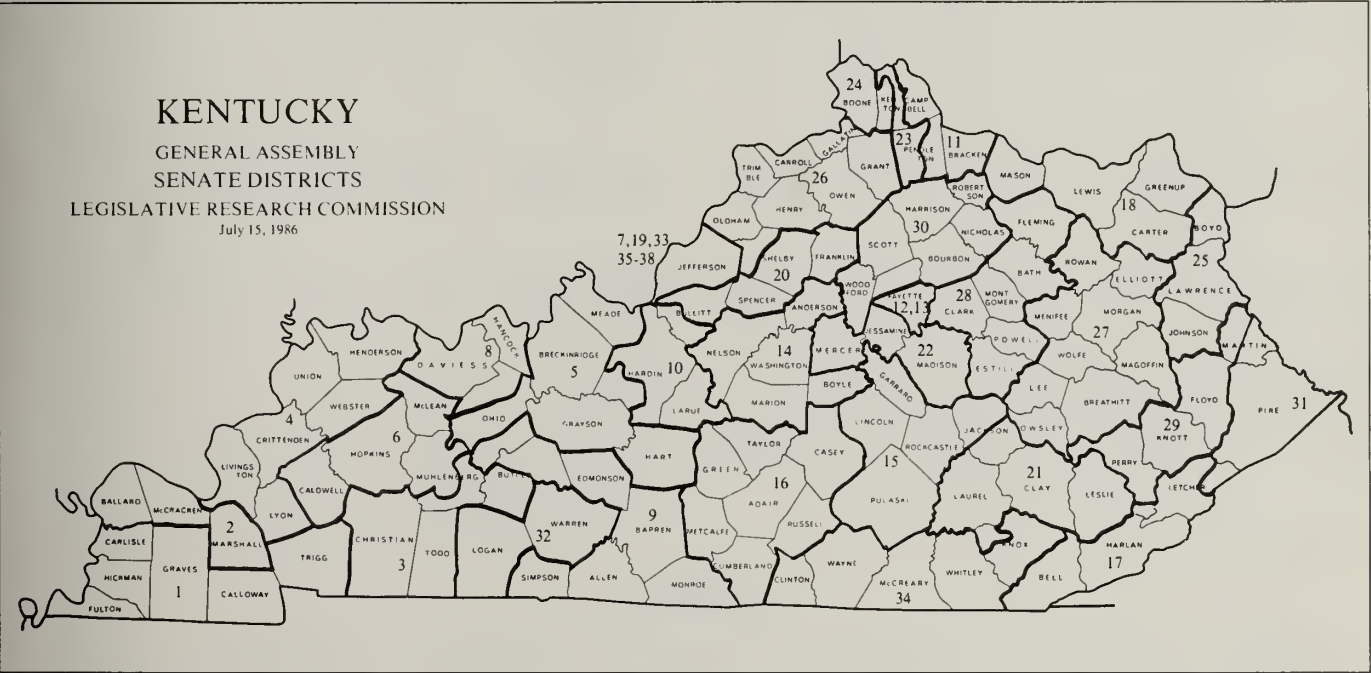
A vetoed bill can be sent back to the Legislature (first to the chamber where it originated) and the veto can be overridden by a constitutional majority.

Most legislation becomes law 90 days after the General Assembly adjourns.



KENTUCKY LEGISLATIVE DISTRICT MAPS

If you are unsure of your district, contact the Voter Registrar or County Clerk in your area.



LEGISLATIVE CALENDAR 1992 KENTUCKY GENERAL ASSEMBLY

JANUARY

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1	2	3	4
5	6	⑦ Session Convenes	⑧	⑨	⑩	11
12	⑬	⑭	⑮	⑯	⑰	18
19 Holiday	20 Holiday	⑳	㉑	㉒	㉓	25
26	㉔	㉕	㉖	30 Holiday	31 Holiday	

FEBRUARY

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1
2	③	④	⑤	⑥	⑦	8
9	⑩	⑪	12 Holiday	⑬	⑭	15
16	17 Holiday	⑱	⑲	⑳	㉑	22
23	㉒	㉓ Last day for new bill requests	㉔	㉕	㉖	29

MARCH

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2	3	4	5 Last day for new House Bills	6 Last day for new Senate Bills	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31 Concurrence only				

APRIL

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			1 Concurrence only	2 VETO	3 VETO	4 VETO
5	6 VETO	7 VETO	8 VETO	9 VETO	10 VETO	11 VETO
12	13 VETO	14	15 Session Adjourns	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

NOTE: The days the Kentucky General Assembly will be in Session are indicated by bold dates in circles.

KMA SALUTES —

Senator Nick Kafoglis, MD —
The only physician member of the Kentucky General Assembly, has served for 10 years.



Senator Kafoglis is pictured with Senator Tim Shaughnessy.



L to R — Senators Benny Ray Bailey, Charles Berger, and Nick Kafoglis, MD.

Representative Susan Stokes —

Wife of Lowell Stokes, MD, has been a member of the Kentucky General Assembly for three years.



L to R — Representatives Bill Lear, Jim LeMaster, and Susan Stokes.

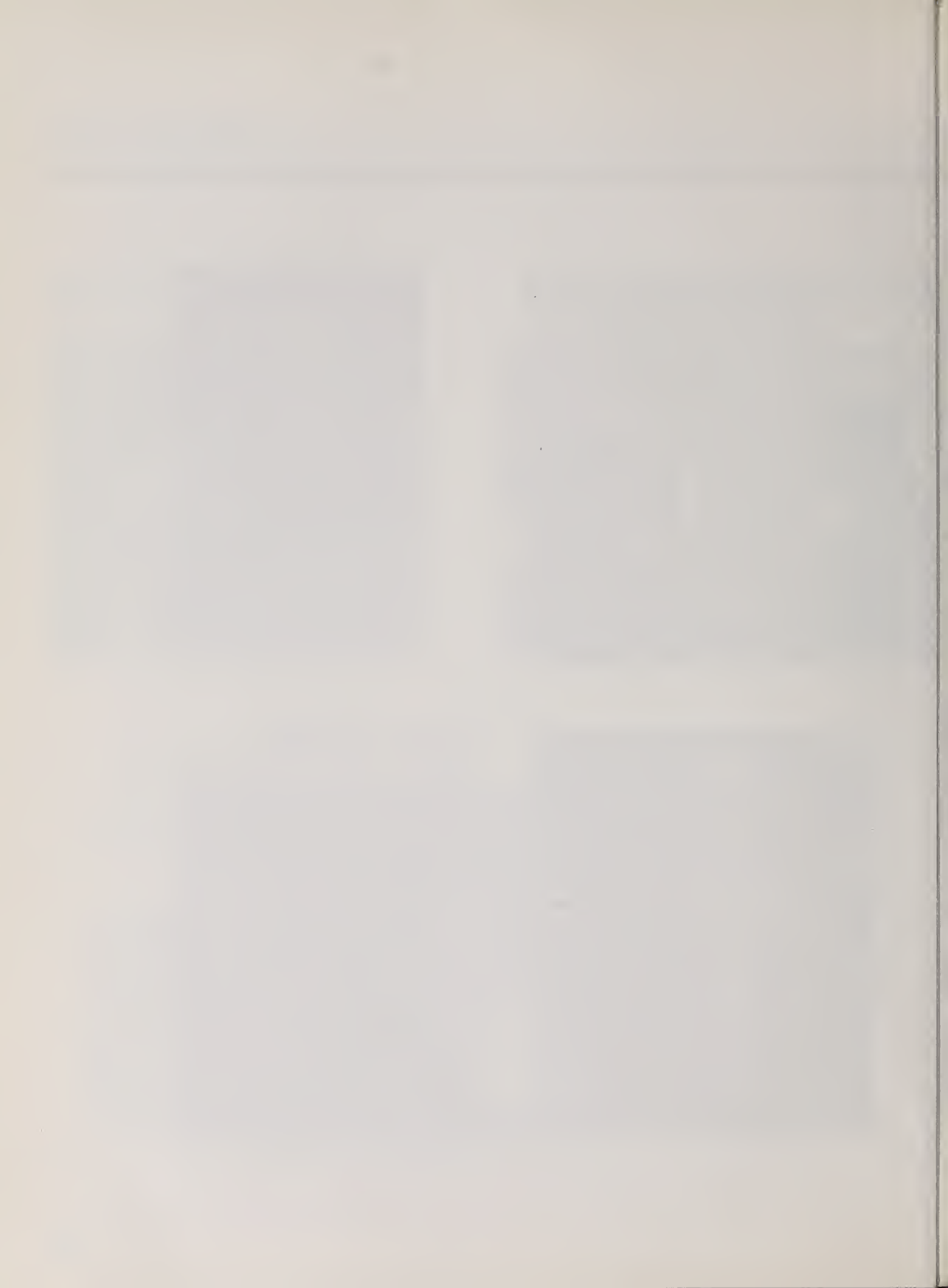


Senator Joe Wright —

In 1992, the Senate Majority Floor Leader, Joe Wright of Harned, will retire from the Kentucky General Assembly. Senator Wright has been an advocate of patients and has been a strong supporter of good health and medical legislation. The Kentucky Medical Association recognizes his outstanding service to the Commonwealth and his constituents.



Senator Wright is pictured with Senate President Pro Tem John "Eck" Rose.



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(Home) 502-885-4029
Page 32

Ray Mullinix (53)
208 Baker Street
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(Home) 502-864-3881
Page 39

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(Home) 606-792-4860
Page 36

Charles Nelson (15)
PO Box 5
Bremen, KY 42325
(Home) 502-525-3464
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Harlan, KY 40831
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Page 45

Clarence D. Noland, Jr (84)
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Page 44

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(Home) 606-787-7062
Page 39

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Page 43

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Page 32

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(Office) 502-348-9223
(Office) 502-348-3523
(Home) 502-348-3596
Page 39

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(Home) 606-635-3455
Page 42

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(Home) 502-639-5402
Page 32

*Steve Riggs (31)
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Louisville, KY 40220
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Louisville, KY 40204
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923 Sulphur Road
Smiths Grove, KY 42171
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804 First National Building
167 W. Main
Lexington, KY 40507
(Office) 606-254-5766
(Home) 606-254-3681
Page 43

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310 View Place
Ludlow, KY 41016
(Office) 606-261-3200
(Home) 606-254-3681
Page 41

Billy Ray Smith (21)
2085 Barren River Road
Bowling Green, KY 42101
(Office) 502-843-3294
(Home) 502-782-1294
Page 34

Rex Smith (4)
Box 27
Grand Rivers, KY 42045
(Office) 502-362-8661
(Home) 502-898-7787
Page 31

Tom O'Dell Smith (86)
Route 1, Box 338
Gray, KY 40734
(Office) 606-546-8015
(Home) 606-546-5040
Page 45

*Susan B. Stokes (48)
440 Country Lane
Louisville, KY 40207
(Home) 502-897-7977
Page 38

William R. Strong (39)
PO Box 7012
Hazard, KY 41701
(Office) 606-439-4571
(Home) 606-439-4837
Page 37

Gregory D. Stumbo (95)
Fred's Fork
Prestonsburg, KY 41653
(Office) 606-285-9228
(Home) 606-886-9953
Page 46

*Jerry Toby (45)
7114 Deanna Drive
Louisville, KY 40219
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Route 2
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(Home) 606-636-6124
Page 44

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Page 34

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7300 Turfway Road
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(Office) 606-283-0515
(Home) 606-341-9064
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*Mike Ward (34)
1905 Deer Park Avenue
Louisville, KY 40205
(Office) 502-587-0954
(Home) 502-451-3867
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*Jim Wayne (35)
1280 Royal Avenue
Louisville, KY 40204
(Home) 502-451-3867
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Gex (Jay) Williams (60)
14142 Walton-Verona Road
Verona, KY 41092
(Office) 513-579-0455
(Home) 606-485-4438
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Pete Worthington (70)
RR No. 1, Box 131
Ewing, KY 41039
(Office) 606-232-3034
(Home) 606-267-3281
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*James Bernard Yates (44)
2305 Thurman Drive
Shively, KY 40216
(Office) 502-452-1578
(Home) 502-447-9453
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James F. Zimmerman (59)
3404 Sycamore Road
LaGrange, KY 40031
(Home) 502-241-4025
Page 40

*(Delegation Office) 502-583-0569

ROSTER OF KENTUCKY GENERAL ASSEMBLY MEMBERS — 1992

KENTUCKY STATE SENATE

DISTRICT 1

C. Greg Higdon (D)

Route 2
Fancy Farm, KY 42039
(502) 444-6547 (O)
623-8628 (H)
Counties: Calloway, Carlisle, Fulton,
Graves, Hickman, Trigg
Profession: Businessman
Religious Affiliation: Catholic
Birthday: May 13
Education: Brescia College, BS
Legislative Service: Senate 1982-92
Committee Assignments: Banking & Insurance, Rules
KMA Key Contact: Bill Jackson, MD, Mayfield
(502) 247-8100 (O)



DISTRICT 4

Henry G. Lackey (D)

305 South Main Street
Henderson, KY 42420
(502) 827-9865 (O)
826-9375 (H)
Counties: Crittenden, Henderson, Living-
ston, Lyon, Union, Webster
Profession: Broadcaster, Radio Station
Owner
Religious Affiliation: Presbyterian
Birthday: May 18
Education: U of K, BA; Michigan State U, MA
Legislative Service: Senate 1982-1986, 1992
Committee Assignments: Rules, Health & Welfare, Transportation
KMA Key Contact: Paul E. Moore, MD, Henderson
(502) 827-0030



DISTRICT 2

Robert J. Leeper (D)

3307 Lone Oak Road
Paducah, KY 42001
(502) 554-9637 (O)
442-4469 (H)
Counties: Ballard, McCracken, Marshall
Profession: Office Manager
Religious Affiliation: Baptist
Birthday: Dec 8
Education: Paducah Community
College; Sherman College of Chiropractic
Legislative Service: Senate 1992
Committee Assignments: Health & Welfare, Transportation
KMA Key Contact: Larry C. Franks, MD, Paducah
(502) 442-7181 (O)



DISTRICT 5

Joe Wright (D)

Star Route
Harned, KY 40144
(502) 756-5678 (H)
Counties: Breckinridge, Grayson, Hardin,
Hart, Meade, Ohio
Profession: Farmer
Religious Affiliation: Methodist
Birthday: July 29
Education: U of K, BS
Legislative Service: Senate 1976-1992
Committee Assignments: Rules, Appropriations & Revenue
KMA Key Contact: James G. Sills, MD, Harned
(502) 756-2178 (O)



DISTRICT 3

Pat M. McCuiston (D)

147 Main Street
Pembroke, KY 42266
(502) 475-4232 (H)
Counties: Butler, Christian, Muhlenberg,
Todd
Profession: Retired Banker
Religious Affiliation: Baptist
Birthday: Sept 8
Education: Murray State U, BS; U of K;
Western Kentucky U
Legislative Service: Senate 1968-1992
Committee Assignments: Appropriations & Revenue, Banking &
Insurance, State Government, Elections & Constitutional
Amendments
KMA Key Contact: Sam H. Traughber, MD, Hopkinsville
(502) 886-0251 (O)



DISTRICT 6

Kim L. Nelson (D)

PO Box 984
Madisonville, KY 42431
(502) 821-3355 (O)
825-3661 (H)
Counties: Caldwell, Hopkins, McLean,
Muhlenberg
Profession: CPA
Religious Affiliation: Methodist
Birthday: Feb 19
Education: Murray State U, BS
Legislative Service: Senate 1989-1992
Committee Assignments: Transportation
KMA Key Contact: James L. Beck, MD, Madisonville
(502) 825-7469 (O)



DISTRICT 7

W. L. Quinlan (D)

8214 Seaforth Drive
Louisville, KY 40258
(502) 364-3705 (O)
937-3870 (H)

County: Jefferson

Profession: Industrial engineer

Religious Affiliation: Catholic

Birthday: Dec 25

Education: U of L, BSC

Legislative Service: Senate 1972-1992

Committee Assignments: Banking & Insurance, Business

Organizations & Professions

KMA Key Contact: (to be announced)



DISTRICT 10

Tom Smith (D)

PO Box 267
Elizabethtown, KY 42702
(502) 737-7322 (O)
369-7039 (H)

Counties: Bullitt, Hardin, Larue

Profession: Self-employed

Religious Affiliation: Baptist

Birthday: Nov 26

Legislative Service: Senate 1992

Committee Assignments: Banking
& Insurance

KMA Key Contact: Lucian Y. Moreman, II, MD, Elizabethtown
(502) 769-5963 (O)



DISTRICT 8

David E. Boswell (D)

2130 Woodland Drive
Owensboro, KY 42301
(502) 771-4921 (H)

Counties: Daviess, Hancock, Ohio

Profession: Self-employed

Religious Affiliation: Catholic

Birthday: Nov 20

Education: Western Kentucky U; Brescia
College

Legislative Service: House 1978-1982, Senate 1992

Committee Assignments: Banking & Insurance, Business

Organizations & Professions

KMA Key Contact: Donald R. Neel, MD, Owensboro
(502) 926-9821 (O)



DISTRICT 11

Arthur L. Schmidt (R)

134 Winters Lane
Cold Spring, KY 41076
(606) 441-5555 (H)

Counties: Bracken, Campbell, Pendleton

Profession: Businessman

Religious Affiliation: Catholic

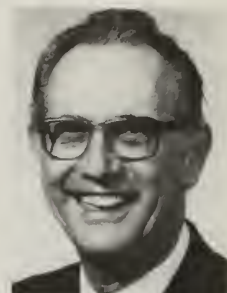
Birthday: May 1

Education: U of K

Legislative Service: House 1964-1965,
1968-1982; Senate 1984-1992

Committee Assignments: Rules, Business Organizations &
Professions, State Government, Elections & Constitutional
Amendments

KMA Key Contact: Edward R. Elicker, MD, Ft. Mitchell
(606) 341-2672 (O)



DISTRICT 9

Walter A. Baker (R)

917 South Green Street
Glasgow, KY 42141
(502) 651-3715 (O)
651-8116 (H)

Counties: Allen, Barren, Butler,
Edmonson, Monroe, Ohio, Simpson

Profession: Attorney

Religious Affiliation: Presbyterian

Birthday: Feb 20

Education: Harvard College, AB; Harvard Law School, LLB

Legislative Service: House 1968-1972; Senate 1972-1981, 1989-1992

Committee Assignments: Judiciary, Labor & Industry

KMA Key Contact: Jerry L. Gibbs, MD, Glasgow
(502) 651-4166 (O)



DISTRICT 12

Timothy N. Philpot (R)

3475 Lyon Drive #56
Lexington, KY 40513
(606) 255-7761 (O)
224-3093 (H)

County: Fayette

Profession: Attorney

Religious Affiliation: Methodist

Birthday: Mar 18

Education: U of K, BA, JD

Legislative Service: Senate 1992

Committee Assignments: Judiciary, Transportation

KMA Key Contact: Russell L. Travis, MD, Lexington
(606) 277-6143 (O)



SENATE

DISTRICT 13

Michael R. Moloney (D)

Old Northern Bank Bldg
259 West Short Street
Lexington, KY 40507
(606) 255-7946 (O)
268-1784 (H)

County: Fayette

Profession: Attorney

Religious Affiliation: Catholic

Birthday: Jan 25

Education: Xavier U, BS; U of K, LLB

Legislative Service: Senate 1972-1992

Committee Assignments: Appropriations & Revenue, Judiciary

KMA Key Contact: Andrew R. Pulito, MD, Lexington
(606) 233-5625 (O)



DISTRICT 16

David L. Williams (R)

PO Box 666
Burkesville, KY 42717
(502) 864-5636 (O)
864-2640 (H)

Counties: Adair, Casey, Cumberland,
Green, Metcalfe, Russell, Taylor

Profession: Attorney

Religious Affiliation: Methodist

Birthday: May 28

Education: U of K, bachelors; U of L, JD

Legislative Service: House 1985-1986; Senate 1987-1992

Committee Assignments: Judiciary, Labor & Industry

KMA Key Contact: (to be announced)



DISTRICT 14

Dan Kelly (R)

107 Covington
Springfield, KY 40069
(606) 336-7723 (O)
336-9048 (H)

Counties: Anderson, Boyle, Marion,
Nelson, Washington

Profession: Attorney

Religious Affiliation: Church of
Jesus Christ of Latter-day Saints

Birthday: Aug 29

Education: Texas A & M, BS; U of L, JD

Legislative Service: Senate 1992

Committee Assignments: Appropriations & Revenue

KMA Key Contact: (to be announced)



DISTRICT 17

Charles W. Berger (D)

PO Box 689
Pineville, KY 40977
(606) 337-3047 (O)
573-2962 (H)

Counties: Bell, Harlan, Perry, Letcher

Profession: Attorney

Religious Affiliation: Baptist

Birthday: Jan 12

Education: U of K, BS; U of Tennessee,
JD

Legislative Service: Senate 1980-1992

Committee Assignments: Rules, Appropriations & Revenue,
Judiciary

KMA Key Contact: Kenneth Hurlocker, MD, Harlan
(606) 573-4520 (O)
J.D. Miller, MD, Evarts
(606) 837-2108 (O)



DISTRICT 15

John D. Rogers (R)

PO Box 518
Somerset, KY 42501
(606) 679-6396 (O)

Counties: Garrard, Jackson, Lincoln,
Pulaski, Rockcastle

Profession: Attorney, businessman

Religious Affiliation: Baptist

Birthday: July 18

Education: Eastern Kentucky U, BA, MA;
U of L, JD

Legislative Service: Senate 1976-1992

Committee Assignments: Rules, Banking & Insurance, Business
Organizations & Professions

KMA Key Contact: James D. Crase, MD, Somerset
(606) 679-9268 (O)



DISTRICT 18

Charlie Borders (R)

330 Seaton Drive
Russell, KY 41169
(606) 836-1721 (H)

Counties: Carter, Greenup, Lewis,
Mason

Profession: Oil Company Executive

Religious Affiliation: Nazarene

Birthday: May 27

Education: Ashland Community College; Southeastern Christian
College; Morehead State U, BS, MBA

Legislative Service: Senate 1992

Committee Assignments: Appropriations & Revenue
KMA Key Contact: Malcolm H. King, MD, Ashland
(606) 325-9633 (O)



DISTRICT 19

Tim Shaughnessy (D)

Suite 103, 250 East Liberty

Louisville, KY 40202

(502) 584-1920 (O)

231-0739 (H)

County: Jefferson

Profession: Executive Director, hospital properties

Religious Affiliation: Catholic

Birthday: Aug 22

Education: Jefferson Community College; U of L, BS; Bellarmine College, MBA

Legislative Service: Senate 1989-1992

Committee Assignments: Banking & Insurance, Labor & Industry

KMA Key Contact: Gregory E. Gleis, MD, Louisville

(502) 581-9061 (O)



DISTRICT 22

Tom Buford (R)

106 Clubhouse Drive

Nicholasville, KY 40356

(606) 223-7171 (H)

Counties: Jessamine, Madison, Mercer

Profession: General contractor

Religious Affiliation: Disciples of Christ

Birthday: May 26

Education: U of K, BS; American Institute of Banking

Legislative Service: Senate 1992

Committee Assignments: Rules, Banking & Insurance, Business Organizations & Professions, Health & Welfare

KMA Key Contact: Stephen S. Draper, MD, Nicholasville

(606) 885-9402 (O)



DISTRICT 20

Fred Bradley (D)

Indian Ridge Farm

855 South Benson Road

Frankfort, KY 40601

(502) 227-4443 (H)

Counties: Bullitt, Franklin, Shelby, Spencer

Profession: Attorney, farmer, owner/president of company

Religious Affiliation: Episcopalian

Birthday: Apr 26

Education: U of K, ABJ, LLB, JD

Legislative Service: Senate 1982-1992

Committee Assignments: Business Organizations & Professions

KMA Key Contact: O.M. Patrick, MD, Frankfort

(502) 223-7629 (O)



DISTRICT 23

Joseph U. Meyer (D)

106 West Eleventh Street

Covington, KY 41011

(606) 491-9696 (O)

431-0413 (H)

Counties: Kenton, Pendleton

Profession: Attorney

Religious Affiliation: Catholic

Birthday: Sept 10

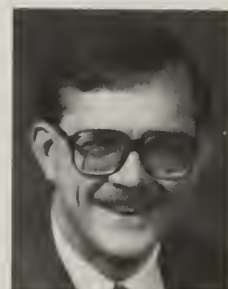
Education: Bellarmine College, AB; St. Louis U, MA; Chase College of Law, JD

Legislative Service: House 1982-1988; Senate 1989-1992

Committee Assignments: State Government, Judiciary, Elections & Constitutional Amendments

KMA Key Contact: Mark F. Pelstring, MD, Covington

(606) 291-4768 (O)



DISTRICT 21

Gene Huff (R)

1623 Senator Lane

London, KY 40741

(606) 864-4995 (H)

Counties: Clay, Jackson, Knox, Laurel, Leslie

Profession: Minister

Religious Affiliation: Pentecostal

Birthday: Oct 6

Education: Union College, AB; Morehead State U, MA EdS; U of K

Legislative Service: House 1968-1971; Senate 1972-1992

Committee Assignments: Labor & Industry, Transportation

KMA Key Contact: Paul R. Smith, MD, London

(606) 864-2179 (O)



DISTRICT 24

Richard L. Roeding (R)

2227 Grace Avenue

Ft. Mitchell, KY 41017

(606) 331-1684 (H)

Counties: Boone, Kenton

Profession: Pharmacist

Religious Affiliation: Catholic

Birthday: Nov 28

Education: Xavier U; U of Cincinnati, BS

Legislative Service: Senate 1992

Committee Assignments: Health & Welfare, State Government, Elections & Constitutional Amendments

KMA Key Contact: William B. Monnig, MD, Edgewood

(606) 341-2672 (O)



SENATE

DISTRICT 25

David LeMaster (D)

PO Drawer 272
Paintsville, KY 41240
(606) 789-6531 (O)
789-6247 (H)

Counties: Boyd, Floyd, Johnson,
Lawrence

Profession: Attorney

Religious Affiliation: Christian

Birthday: May 1

Education: U of K, BA, JD

Legislative Service: Senate 1984-1992

Committee Assignments: Business Organizations & Professions,
Labor & Industry

KMA Key Contact: Jerry D. Fraim, MD, Paintsville
(606) 789-3578 (O)



DISTRICT 28

John A. Rose (D)

PO Box 511
Winchester, KY 40391
(606) 744-4338 (H)

Counties: Bath, Clark, Estill, Fleming,
Montgomery, Powell

Profession: Realtor-auctioneer, farmer

Religious Affiliation: Methodist

Birthday: June 1

Education: Eastern Kentucky U, BS

Legislative Service: Senate 1978-1992

Committee Assignments: Rules, State Government,

Transportation, Elections & Constitutional Amendments

KMA Key Contact: Harold S. Moberly, Jr, MD, Winchester
(606) 744-2732 (O)



DISTRICT 26

Rick W. Rand (D)

Route 2, Box 356
Bedford, KY 40006
(502) 255-3286 (O)
255-3392 (H)

Counties: Carroll, Gallatin, Grant, Henry,
Oldham, Owen, Shelby, Trimble

Profession: Independent Insurance Agent

Religious Affiliation: Christian

Birthday: Mar 10

Education: Hanover College, BA

Legislative Service: Senate 1992

Committee Assignments: State Government, Elections &
Constitutional Amendments

KMA Key Contact: (to be announced)



DISTRICT 29

Benny Ray Bailey (D)

Box 849
Hindman, KY 41822
(606) 785-3164 (O)
785-5327 (H)

Counties: Floyd, Knott, Martin, Perry

Profession: Clinic administrator

Religious Affiliation: Baptist

Birthday: Nov 16

Education: Alice Lloyd College, AA; Pikeville College, BA;
Indiana State U, MS; Ohio U, PhD

Legislative Service: Senate 1980-1992

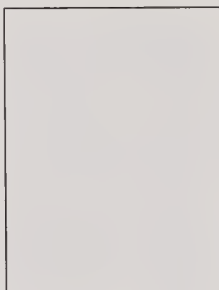
Committee Assignments: Appropriations & Revenue, Health
& Welfare

KMA Key Contact: (to be announced)



DISTRICT 27

VACANT



DISTRICT 30

Ed Ford, DVM (D)

315 East Pike Street
Cynthiana, KY 41031
(606) 224-2850 (O)
234-1164 (H)

Counties: Bourbon, Fayette, Harrison,
Nicholas, Robertson, Scott, Woodford

Profession: Veterinarian

Religious Affiliation: Methodist

Birthday: Jan 1

Education: Auburn U, DVM

Legislative Service: Senate 1978-1992

Committee Assignments: State Government, Elections &
Constitutional Amendments

KMA Key Contact: Don R. Stephens, MD, Cynthiana
(606) 234-4494 (O)



DISTRICT 31**Kelsey E. Friend (D)**

PO Box 512
 Pikeville, KY 41501
 (606) 437-4026 (O)
 437-4616 (H)
 Counties: Letcher, Martin, Pike
 Profession: Attorney
 Religious Affiliation: Methodist
 Birthday: Mar 18
 Education: Pikeville College; U of K, LLB; Duke U, LLM
 Legislative Service: Senate 1972-1979, 1984-1992
 Committee Assignments: Judiciary, Labor & Industry,
 State Government, Elections & Constitutional Amendments
 KMA Key Contact: Harvey A. Page, MD, Pikeville
 (606) 432-2872 (O)

**DISTRICT 34****Landon C. Sexton (R)**

HC 82, Box 846
 Pine Knot, KY 42635
 (606) 376-2222 (O)
 354-2286 (H)
 Counties: Clinton, Knox, McCreary,
 Wayne, Whitley
 Profession: School principal, evangelist
 Religious Affiliation: Protestant
 Birthday: Dec 28
 Education: Tennessee Technological U, BS, MA; U of Georgia,
 EdS; Eastern Kentucky U
 Legislative Service: Senate 1987-1992
 Committee Assignments: Health & Welfare
 KMA Key Contact: Don C. Barton, MD, Corbin
 (606) 528-2124 (O)

**DISTRICT 32****Nick Kafoglis, MD (D)**

1008 Newman Drive
 Bowling Green, KY 42101
 (502) 781-3414 (O)
 843-4127 (H)
 Counties: Logan, Warren
 Profession: Physician
 Religious Affiliation: Disciples of Christ
 Birthday: Jan 16
 Education: Yale U, BA; U of Pennsylvania, MD
 Legislative Service: House 1972-1976; Senate 1987-1992
 Committee Assignments: Rules, Appropriations & Revenue,
 Transportation
 KMA Key Contact: Nelson B. Rue, MD, Bowling Green
 (502) 781-5111 (O)

**DISTRICT 35****David K. Karem (D)**

2439 Ransdell Avenue
 Louisville, KY 40204
 (502) 625-3768 (O)
 454-4174 (H)
 County: Jefferson
 Profession: Attorney
 Religious Affiliation: Catholic
 Birthday: Aug 31
 Education: U of Cincinnati, BS; U of L, JD
 Legislative Service: House 1972-1974; Senate 1976-1992
 Committee Assignments: Rules, Judiciary
 KMA Key Contact: William P. VonderHaar, MD, Louisville
 (502) 589-0260 (O)

**DISTRICT 33****Gerald A. Neal (D)**

1718 West Jefferson
 Louisville, KY 40203
 (502) 584-8500 (O)
 778-1178 (H)
 County: Jefferson
 Profession: Attorney
 Religious Affiliation: Catholic
 Birthday: Sept 22
 Education: Kentucky State U, BA; U of L, JD; U of Michigan
 Legislative Service: Senate 1989-1992
 Committee Assignments: Appropriations & Revenue, Health
 & Welfare
 KMA Key Contact: Ralph C. Morris, MD, Louisville
 (502) 774-8787 (O)
 Beverly M. Gaines, MD, Louisville
 (502) 585-2924 (O)

**DISTRICT 36****Susan D. Johns (D)**

3120 Runnymede Road
 Louisville, KY 40222
 (502) 569-5613 (O)
 426-6990 (H)
 County: Jefferson
 Profession: Corporate Manager
 Religious Affiliation: Baptist
 Birthday: Oct 7
 Education: Georgetown College, BA, MA
 Legislative Service: Senate 1992
 Committee Assignments: Rules, Health & Welfare,
 Labor & Industry
 KMA Key Contact: Stephen L. Henry, MD, Louisville
 (502) 588-5319 (O)
 R. John Ellis, Jr., MD, Louisville
 (502) 584-5547 (O)



SENATE

DISTRICT 37

Daniel Seum (D)

326 East Esplanade
Louisville, KY 40214
(502) 366-3500 (O)
367-1050 (H)

County: Jefferson

Profession: Restaurant owner

Religious Affiliation: Christian

Birthday: Jan 28

Education: Albert Pick Hotel Restaurant Management Program;
Graduate, Officer's Candidate School, National Guard

Legislative Service: House 1982-1988; Senate 1989-1992

Committee Assignments: Business Organizations & Professions,
Transportation, Labor & Industry

KMA Key Contact: Robert L. Nold, MD, Louisville
(502) 361-8801 (O)



DISTRICT 38

Daniel J. Meyer (D)

603 East Brandeis Avenue
Louisville, KY 40217
(502) 636-2616 (H)

County: Jefferson

Profession: Safety inspector

Religious Affiliation: Catholic

Birthday: Mar 16

Legislative Service: Senate 1978-1992

Committee Assignments: Business Organizations & Professions

KMA Key Contact: (to be announced)



KENTUCKY HOUSE OF REPRESENTATIVES

DISTRICT 1

Charles R. Geveden (D)

PO Box 518
Wickliffe, KY 42087
(502) 335-3186 (O)
335-3683 (H)
Counties: Ballard, Carlisle, Fulton,
Hickman, McCracken
Profession: Attorney
Religious Affiliation: Baptist
Birthday: Mar 3
Education: Vanderbilt U, BA; U of L, JD
Legislative Service: House 1988-1992
Committee Assignments: Judiciary, State Government, Rules
KMA Key Contact: Jesse M. Hunt, Jr, MD, Wickliffe
(502) 335-3199 (O)
Richard D. Smith, MD, Paducah
(502) 442-3559 (O)



DISTRICT 4

Rex Smith (D)

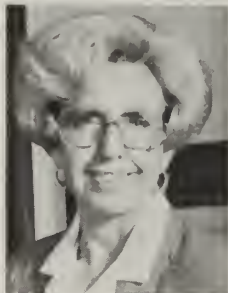
Box 27
Grand Rivers, KY 42045
(502) 362-8661 (O)
898-7787 (H)
Counties: Crittenden, Livingston,
McCracken
Profession: Highway contractor
Religious Affiliation: Baptist
Birthday: Jan 29
Education: Paducah Community College
Legislative Service: House 1987-1992
Committee Assignments: Banking & Insurance
KMA Key Contact: Wally O. Montgomery, MD, Paducah
(502) 443-5371 (O)



DISTRICT 2

Robbie Castleman (D)

704 Weda
Mayfield, KY 42066
(502) 247-2965 (H)
County: Graves
Profession: Legislator
Religious Affiliation: Baptist
Birthday: Feb 27
Education: Murray State U
Legislative Service: House 1992
Committee Assignments: Health & Welfare
KMA Key Contact: Stuart L. Brodsky, MD, Mayfield
(502) 247-4080 (O)



DISTRICT 5

Freed Curd (D)

1607 Sycamore
Murray, KY 42071
(502) 753-9378 (O)
753-5841 (H)
Counties: Calloway, Trigg
Profession: Teacher
Religious Affiliation: Church of Christ
Birthday: Mar 18
Education: Murray State U, BS, MA
Legislative Service: House 1980-1992
Committee Assignments: Appropriations & Revenue,
Transportation
KMA Key Contact: Robert C. Hughes, MD, Murray
(502) 759-9200 (O)



DISTRICT 3

Albert Jones (D)

2807 Broadway
Paducah, KY 42001
(502) 442-1422 (O)
443-8301 (H)
County: McCracken
Profession: Attorney
Religious Affiliation: Episcopalian
Birthday: Nov 11
Education: Paducah Junior College;
U of K, JD
Legislative Service: House 1987-1992
Committee Assignments: Banking & Insurance, Labor & Industry,
State Government
KMA Key Contact: Wally O. Montgomery, MD, Paducah
(502) 443-5371 (O)



DISTRICT 6

Richard H. Lewis (D)

1100 Main Street, Box 430
Benton, KY 42025
(502) 527-1343 (O)
527-9312 (H)
Counties: Caldwell, Lyon, Marshall
Profession: Attorney
Religious Affiliation: Baptist
Birthday: Dec 3
Education: Murray State U, BS;
U of K, JD
Legislative Service: House 1970-1975, 1989-1992
Committee Assignments: Banking & Insurance, Judiciary
KMA Key Contact: H. W. Ford, MD, Benton
(502) 527-8601 (O)



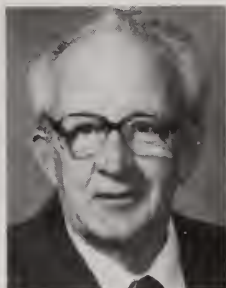
HOUSE

DISTRICT 7

Sam M. McElroy (D)

Route 1, Box 73
Waverly, KY 42462
(502) 389-3940 (O)
389-2710 (H)

Counties: Daviess, Henderson, Union
Profession: Agribusiness
Religious Affiliation: Presbyterian
Birthday: Apr 14
Education: U of K, BS
Legislative Service: House 1984-1992
Committee Assignments: Transportation
KMA Key Contact: (to be announced)



DISTRICT 10

Joseph Eddie Ballard (D)

1811 Grampian Drive
Madisonville, KY 42431
(502) 821-4767 (O)
821-6255 (H)

County: Hopkins
Profession: Self-employed businessman
Religious Affiliation: Catholic
Birthday: Dec 16
Legislative Service: House 1987-1992
Committee Assignments: Banking & Insurance, State Government
KMA Key Contact: (to be announced)



DISTRICT 8

H. Ramsey Morris, Jr (D)

PO Box 4030
Hopkinsville, KY 42240
(502) 886-0701 (O)
885-4029 (H)

Counties: Christian, Trigg
Profession: Businessman, tobacco products
Religious Affiliation: Christian
Birthday: Nov 7
Legislative Service: House 1976-1992
Committee Assignments: Banking & Insurance, State Government, Health & Welfare
KMA Key Contact: Sam H. Traugher, MD, Hopkinsville
(502) 886-0251 (O)



DISTRICT 11

A. G. Pritchett (D)

9632 Corydon Geneva Road
Henderson, KY 42420
(502) 533-6276 (H)

County: Henderson
Profession: Farmer
Religious Affiliation: Methodist
Birthday: Feb 18
Education: Western Kentucky U;
Evansville College
Legislative Service: House 1985-1992
Committee Assignments: Transportation
KMA Key Contact: John A. Logan, III, MD, Henderson
(502) 827-7353 (O)



DISTRICT 9

James E. Bruce (D)

6750 Ft. Campbell Boulevard
Hopkinsville, KY 42240
(502) 886-2422 (H)

Counties: Christian, Hopkins
Profession: Farmer
Religious Affiliation: Methodist
Birthday: Aug 17
Education: U of Tennessee, BS
Legislative Service: House 1964-1992
Committee Assignments: Banking & Insurance, State Government, Elections & Constitutional Amendments
KMA Key Contact: J. Nicholas Terhune, MD, Hopkinsville
(502) 886-2020 (O)



DISTRICT 12

J. Dorsey Ridley (D)

303 South Main Street
Providence, KY 42409
(502) 667-2005 (O)
639-5402 (H)

Counties: Caldwell, Crittenden, Hopkins, McLean, Webster
Profession: Automobile dealer
Religious Affiliation: Presbyterian
Birthday: Nov 26
Education: Western Kentucky U, BS
Legislative Service: House 1988-1992
Committee Assignments: Banking & Insurance, Transportation
KMA Key Contact: Loman C. Trover, MD, Madisonville
(502) 825-7200 (O)



DISTRICT 13**E. Louis Johnson (D)**

1511 Kent Place
Owensboro, KY 42301
(502) 926-1717 (O)
685-1514 (H)
County: Daviess
Profession: Attorney
Religious Affiliation: Christian
Birthday: Aug 8
Education: U of K, BS, JD
Legislative Service: House 1978-1992
Committee Assignments: Rules, Judiciary, State Government
KMA Key Contact: Donald R. Neel, MD, Owensboro
(502) 926-9821 (O)

**DISTRICT 16****June D. Lyne (D)**

Route 1
Olmstead, KY 42265
(502) 726-3076 (H)
Counties: Logan, Todd
Profession: Farmer, office manager
Religious Affiliation: Church of Christ
Birthday: Sept 28
Legislative Service: House 1985-1992
Committee Assignments:
KMA Key Contact: Henry R. Bell, MD, Elkton
(502) 265-2574 (O)

**DISTRICT 14****Donald J. Blandford (D)**

PO Box 69
Philpot, KY 42366-0069
(502) 729-4786 (H)
County: Daviess
Profession: Farmer
Religious Affiliation: Catholic
Birthday: Apr 4
Legislative Service: House 1968-1992
Committee Assignments: Rules
KMA Key Contact: Albert H. Joslin, MD, Owensboro
(502) 684-3265 (O)

**DISTRICT 17****Willard C. Allen (R)**

Route 2, Box 123
Morgantown, KY 42261
(502) 526-5149 (H)
Counties: Butler, Hancock, Ohio
Profession: Farmer
Religious Affiliation: Church of Christ
Birthday: Apr 21
Education: Murray State U, BS
Legislative Service: House 1974-1992
Committee Assignments: Business Organizations & Professions
KMA Key Contact: Billy R. Allen, MD, Beaver Dam
(502) 274-7104 (O)

**DISTRICT 15****Charles Nelson (D)**

PO Box 5
Bremen, KY 42325
(502) 525-3464 (H)
Counties: McLean, Muhlenberg
Profession: Miner
Religious Affiliation: Baptist
Birthday: Oct 31
Legislative Service: House 1989-1992
Committee Assignments: Labor & Industry
KMA Key Contact: Barry G. Hardison, MD, Greenville
(502) 754-5666 (O)

**DISTRICT 18****Donnie Gedling (D)**

RR 2
Hardinsburg, KY 40143
(502) 788-6579 (H)
Counties: Breckinridge, Hancock, Meade
Profession: Farmer
Religious Affiliation: Catholic
Birthday: Dec 9
Legislative Service: House 1984-1992
Committee Assignments: State Government
KMA Key Contact: James G. Sills, MD, Harned
(502) 756-2178 (O)



HOUSE

DISTRICT 19

Richard A. Sanders, Jr (R)

923 Sulphur Road
Smiths Grove, KY 42171
(502) 597-3417 (H)
Counties: Edmonson, Grayson, Hardin
Profession: Farmer, restaurant owner
Religious Affiliation: Baptist
Birthday: Aug 6
Education: Western Kentucky U
Legislative Service: House 1992
Committee Assignments:
KMA Key Contact: Ray A. Cave, MD, Leitchfield
(502) 259-4666 (O)



DISTRICT 22

Richard A. Turner (R)

Route 4
Tompkinsville, KY 42167
(502) 427-4233 (H)
Counties: Allen, Monroe, Simpson
Profession: Farmer, merchant
Religious Affiliation: Baptist
Birthday: Jan 12
Education: Western Kentucky U, AB
Legislative Service: House 1976-1977,
1980-1992
Committee Assignments: Appropriations & Revenue
KMA Key Contact: (to be announced)



DISTRICT 20

Jody Richards (D)

817 Culpeper Street
Bowling Green, KY 42103
(502) 781-9946 (O)
842-6731 (H)
County: Warren
Profession: Owner, book store
Religious Affiliation: Church of Christ
Birthday: Feb 20
Education: Kentucky Wesleyan College,
AB; U of Missouri, MA; Indiana U
Legislative Service: House 1976-1992
Committee Assignments: Rules, State Government
KMA Key Contact: John E. Downing, MD, Bowling Green
(502) 781-4909 (O)



DISTRICT 23

Stephen R. Nunn (R)

118 Wingate
Glasgow, KY 42141
(502) 651-5286 (H)
Counties: Barren, Metcalfe
Profession: Insurance agent
Religious Affiliation: Christian
Birthday: Nov 4
Education: U of K; Transylvania U, BA;
U of L Law School
Legislative Service: House 1992
Committee Assignments: Judiciary, Labor & Industry
KMA Key Contact: Philip W. Bale, MD, Glasgow
(502) 651-6791 (O)



DISTRICT 21

Billy Ray Smith (D)

2085 Barren River Road
Bowling Green, KY 42101
(502) 843-3294 (O)
782-1294 (H)
Counties: Simpson, Warren
Profession: Businessman, farmer,
cattle-breeder
Religious Affiliation: Baptist
Birthday: Apr 5
Education: Western Kentucky U, BS
Legislative Service: House 1982-1992
Committee Assignments: Banking & Insurance
KMA Key Contact: Jerry W. Martin, MD, Bowling Green
(502) 842-6164 (O)



DISTRICT 24

Dave Hourigan (D)

Route 1
Gravel Switch, KY 40328
(502) 692-6066 (O)
692-4253 (H)
Counties: Hart, Larue, Marion
Profession: Teacher
Religious Affiliation: Catholic
Birthday: May 27
Education: U of K, BA, MA
Legislative Service: House 1987-1992
Committee Assignments: Elections & Constitutional Amendments
KMA Key Contact: J. W. Ratliff, MD, Lebanon
(502) 692-3123 (O)



DISTRICT 25**Chester Gregory (D)**

1220 Pear Orchard Road
Elizabethtown, KY 42701

(502) 737-5616 (O)

765-2519 (H)

County: Hardin

Profession: Owner, fruit markets

Religious Affiliation: Baptist

Birthday: Aug 15

Legislative Service: House 1985-1992

Committee Assignments: Transportation

KMA Key Contact: William M. Carney, MD, Elizabethtown
(502) 765-1616 (O)

**DISTRICT 28****Bill Lile (R)**

11304 Frenchrone Drive
Valley Station, KY 40272

(502) 583-0569 (O)

935-6874 (H)

County: Jefferson

Profession: Teacher

Religious Affiliation: Methodist

Birthday: Jan 6

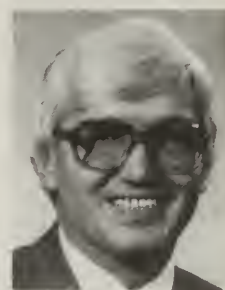
Education: U of K, BA

Western Kentucky U, MA

Legislative Service: House 1972-1973, 1982-1992

Committee Assignments: Business Organizations & Professions

KMA Key Contact: (to be announced)

**DISTRICT 26****Bill D. Ark (D)**

Route 2

Hodgenville, KY 42748

(502) 351-5990 (O)

737-6268 (H)

Counties: Hardin, Larue

Profession: Banker

Religious Affiliation: Methodist

Birthday: Nov 2

Education: U of K School of Banking;

U of Wisconsin, Graduate School of Banking

Legislative Service: House 1987-1992

Committee Assignments: Banking & Insurance, Business

Organizations & Professions

KMA Key Contact: Marion A. Douglass, Jr., MD, Magnolia
(502) 324-3241 (O)

**DISTRICT 29****Lindy Casebier (R)**

10807 Marcitis Road

Louisville, KY 40272

(502) 583-0569 (O)

935-4085 (H)

County: Jefferson

Profession: Teacher

Religious Affiliation: Baptist

Birthday: Dec 27

Education: U of L, Masters, BMed

Legislative Service: House 1987-1992

Committee Assignments: Judiciary, State Government

KMA Key Contact: Nadar H. Al-Shami, MD, Louisville
(502) 933-3313 (O)

**DISTRICT 27****Mark S. Brown (D)**

170 Washington Street

Brandenburg, KY 40108

(502) 422-2101 (O)

422-4225 (H)

Counties: Bullitt, Hardin, Meade

Profession: Pipefitter, mechanical
technician

Religious Affiliation: Catholic

Birthday: Feb 22

Education: Western Kentucky U

Legislative Service: House 1985-1992

Committee Assignments: Rules, Appropriations & Revenue,
Labor & Industry

KMA Key Contact: Charles L. Conley, DO, Brandenburg
(502) 422-4948 (O)

**DISTRICT 30****Thomas J. Burch (D)**

4074 Somoa Way

Louisville, KY 40218

(502) 583-0569 (O)

491-5100 (H)

County: Jefferson

Profession: Production manager

Religious Affiliation: Catholic

Birthday: July 19

Education: Bellarmine College, BA

Legislative Service: House 1972-1975, 1978-1992

Committee Assignments: Business Organizations & Professions,
Health & Welfare

KMA Key Contact: Richard A. Eiferman, MD, Louisville
(502) 588-5454 (O)



HOUSE

DISTRICT 31

Steven Riggs (D)

2832 Richland Avenue
Louisville, KY 40220
(502) 583-0569 (O)
459-0305 (H)

County: Jefferson

Profession: Insurance sales
representative

Religious Affiliation: Methodist

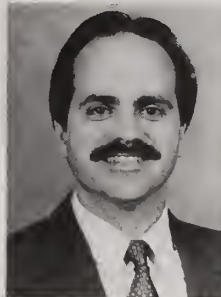
Birthday: June 8

Education: U of K, BBA

Legislative Service: House 1992

Committee Assignments: Banking & Insurance

KMA Key Contact: C. Kenneth Peters, MD, Jeffersontown
(502) 267-5456 (O)



DISTRICT 34

Mike Ward (D)

1905 Deer Park Avenue
Louisville, KY 40205
(502) 587-0954 (O)
451-3867 (H)

County: Jefferson

Profession: Businessman

Religious Affiliation: Episcopalian

Birthday: Jan 7

Education: U of L, BS

Legislative Service: House 1989-1992

Committee Assignments: Appropriations & Revenue, Judiciary

KMA Key Contact: Sam D. Weakley, MD, Louisville
(502) 897-5139 (O)



DISTRICT 32

Anne Meagher Northup (R)

3340 Lexington Road
Louisville, KY 40206
(502) 583-0569 (O)
897-3061 (H)

County: Jefferson

Religious Affiliation: Catholic

Birthday: Jan 22

Education: St. Mary's of Notre Dame, BA,
Economics & Business

Legislative Service: House 1988-1992

Committee Assignments: Transportation

KMA Key Contact: Raymond H. Johnson, MD, Louisville
(502) 245-4168 (O)
Linda H. Gleis, MD, Louisville
(502) 584-3376 (O)



DISTRICT 35

Jim Wayne (D)

1280 Royal Avenue
Louisville, KY 40204
(502) 583-0569 (O)
451-3867 (H)

County: Jefferson

Profession: Psychotherapist

Religious Affiliation: Catholic

Birthday: May 21

Education: Maryknoll College, BA;

Maryknoll School of Technology, MA

Legislative Service: House 1970-1992

Committee Assignments: Labor & Industry, State Government

KMA Key Contact: (to be announced)



DISTRICT 33

Bob Heleringer (R)

14209 Glendower Drive
Louisville, KY 40245
(502) 584-3187 (O)
245-7173 (H)

County: Jefferson

Profession: Attorney

Religious Affiliation: Catholic

Birthday: May 14

Education: Xavier U, BA; U of L, JD

Legislative Service: House 1980-1992

Committee Assignments: Appropriations & Revenue,
Health & Welfare, Judiciary

KMA Key Contact: Frank G. Simon, MD, Louisville
(502) 895-6263 (O)



DISTRICT 36

Lonnie Napier (R)

302 Danville Street
Lancaster, KY 40444
(606) 792-4289 (O)
792-4860 (H)

Counties: Garrard, Jessamine, Madison

Profession: Auctioneer, realtor, farmer,
newspaper editor

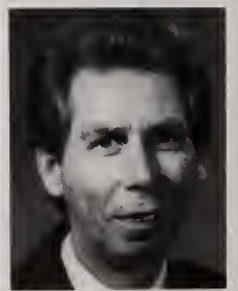
Religious Affiliation: Baptist

Birthday: May 24

Legislative Service: House 1985-1992

Committee Assignments: State Government, Transportation

KMA Key Contact: Clifford Kerby, MD, Berea
(606) 986-8481 (O)



DISTRICT 37**Paul Clark (D)**

4711 South Second Street
Louisville, KY 40214

(502) 583-0569 (O)
368-0098 (H)

County: Jefferson

Profession: Automotive manufacturer

Religious Affiliation: Christian

Birthday: July 11

Education: Kentucky State U

Legislative Service: House 1980-1992

Committee Assignments: Rules, Elections & Constitutional
Amendments, Labor & Industry

KMA Key Contact: Robert L. Nold, MD, Louisville
(502) 361-8801 (O)

**DISTRICT 40****Jerry Bronger (D)**

3500 Robin Drive
Louisville, KY 40216

(502) 473-3109 (O)
448-3097 (H)

County: Jefferson

Profession: Sales

Religious Affiliation: Catholic

Birthday: Dec 1

Legislative Service: House 1980-1992

Committee Assignments: Rules, Business Organizations & Profes-
sions, Elections & Constitutional Amendments

KMA Key Contact: Sam D. Weakley, MD, Louisville
(502) 897-5139 (O)

**DISTRICT 38****Denver Butler (D)**

1533 Southgate Avenue
Louisville, KY 40215

(502) 583-0569 (O)
366-7195 (H)

County: Jefferson

Profession: Meat cutter, supervisor

Religious Affiliation: Catholic

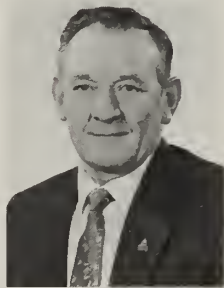
Birthday: Dec 31

Education: Jefferson Community College

Legislative Service: House 1989-1992

Committee Assignments: Business Organizations & Professions,
Labor & Industry

KMA Key Contact: Stuart Cohen, MD, Louisville
(502) 361-2315 (O)

**DISTRICT 41****Tom Riner (D)**

1143 East Broadway
Louisville, KY 40204

(502) 583-0569 (O)
584-3639 (H)

County: Jefferson

Profession: Administrator

Religious Affiliation: Baptist

Birthday: Oct 7

Education: Centre College; Southern

Baptist Theological Seminary; Heritage Baptist U

Legislative Service: House 1982-1992

Committee Assignments: Rules, Health & Welfare

KMA Key Contact: Frank G. Simon, MD, Louisville
(502) 895-6263 (O)

**DISTRICT 39****William R. Strong (R)**

Box 7012
Hazard, KY 41701

(606) 439-4571 (O)
439-4837 (H)

Counties: Harlan, Owsley, Perry

Profession: Insurance agency manager

Religious Affiliation: Presbyterian

Birthday: May 28

Education: Union College, BS

Legislative Service: House 1987-1992

Committee Assignments: Labor & Industry, State Government

KMA Key Contact: Elmer B. Ratcliff, MD, Hazard
(502) 436-6895 (O)

**DISTRICT 42****Leonard Gray (D)**

2301 West Broadway
Louisville, KY 40211

(502) 583-0569 (O)
778-5028 (H)

County: Jefferson

Profession: Sales associate

Religious Affiliation: Catholic

Birthday: June 2

Education: U of L, MS

Legislative Service: House 1989-1992

Committee Assignments: Business Organizations & Professions,
Elections & Constitutional Amendments, State Government

KMA Key Contact: Ralph C. Morris, MD, Louisville

(502) 774-8787 (O)

C. Milton Young, III, MD, Louisville

(502) 583-9900 (O)



HOUSE

DISTRICT 43

E. Porter Hatcher, Jr (D)

901 Southwestern Parkway
Louisville, KY 40211
(502) 774-2331 (O)
778-9051 (H)

County: Jefferson

Profession: Insurance agent; real estate broker

Religious Affiliation: Baptist

Birthday: Sept 9

Education: U of L

Legislative Service: House 1987-1992

Committee Assignments: Banking & Insurance, Business Organizations & Professions, Health & Welfare

KMA Key Contact: Ralph C. Morris, MD, Louisville
(502) 774-8787 (O)



DISTRICT 46

Larry D. Clark (D)

5913 Whispering Hills Boulevard
Louisville, KY 40219
(502) 583-0569 (O)
968-3546 (H)

County: Jefferson

Profession: Electrician

Religious Affiliation: Catholic

Birthday: July 24

Legislative Service: House 1984-1992

Committee Assignments: Rules, Appropriations & Revenue, Business Organizations & Professions

KMA Key Contact: Lafayette G. Owen, MD, Louisville
(502) 583-1749 (O)

Richard F. Greathouse, MD, Louisville
(502) 459-2863 (O)



DISTRICT 44

James Bernard Yates, Sr (D)

2305 Thurman Drive
Shively, KY 40216
(502) 452-1578 (O)
447-9453 (H)

County: Jefferson

Profession: Executive director

Religious Affiliation: Catholic

Birthday: Apr 5

Education: Bellarmine College, BA;

Catherine Spalding College, graduate school

Legislative Service: House 1972-1992

Committee Assignments: Rules, Business Organizations & Professions, State Government

KMA Key Contact: Michael G. Kemper, MD, Louisville
(502) 361-1389 (O)

John Celletti, MD, Louisville
(502) 948-6742 (O)



DISTRICT 47

Jon W. Ackerson (R)

110 Kentucky Towers
Louisville, KY 40202
(502) 587-8111 (O)
244-0032 (H)

County: Jefferson

Profession: Attorney

Religious Affiliation: Catholic

Birthday: July 29

Education: U of L, BA; Indiana U, JD

Legislative Service: Senate 1978-1986; House 1976, 1988-1992

Committee Assignments: Banking & Insurance, Judiciary

KMA Key Contact: Larry P. Griffin, MD, Louisville
(502) 426-4912 (H)



DISTRICT 45

Jerry Toby (R)

7114 Deanna Drive
Louisville, KY 40219
(502) 969-5256 (O)
968-9672 (H)

County: Jefferson

Profession: Tour Company Vice President

Religious Affiliation:

Birthday: Dec 1

Education: Evangel Christian Life Center

Legislative Service: House 1992

Committee Assignments: Labor & Industry, Elections & Constitutional Amendments

KMA Key Contact: (to be announced)



DISTRICT 48

Susan B. Stokes (R)

440 Country Lane
Louisville, KY 40207
(502) 583-0569 (O)
897-7977 (H)

County: Jefferson

Profession: Business manager

Religious Affiliation: Presbyterian

Birthday: June 30

Education: U of Oklahoma, BS;

Hunter College, MS

Legislative Service: House 1989-1992

Committee Assignments: Health & Welfare

KMA Key Contact: Lowell L. Stokes, Jr., MD, Louisville
(502) 897-0667 (O)

Bob M. DeWeese, MD, Louisville
(502) 636-9216 (O)



DISTRICT 49**John Harper (R)**

5550 N. Main
Shepherdsville, KY 40165

(502) 955-7326 (O)
957-4467 (H)

County: Bullitt

Profession: Businessman, engineer,
inventor

Religious Affiliation: Catholic

Birthday: May 3

Education: U of L

Legislative Service: House 1985-1992

Committee Assignments: Rules, Elections & Constitutional
Amendments, Transportation

KMA Key Contact: (to be announced)

**DISTRICT 52****Raymond Overstreet (R)**

Box U, Riverview Estates
Liberty, KY 42539

(606) 787-8347 (O)
787-7062 (H)

Counties: Adair, Casey, Russell

Profession: Attorney

Religious Affiliation: Methodist

Birthday: Dec 3

Education: Berea College, AB; U of K, JD

Legislative Service: House 1972-1992

Committee Assignments: Banking & Insurance, Health & Welfare,
Judiciary

KMA Key Contact: Lewis E. Wesley, MD, Liberty
(606) 787-8348 (O)

**DISTRICT 50****Kenny Rapier (D)**

115 Parkview Drive
Bardstown, KY 40004

(502) 348-9223 (O)
348-3596 (H)

Counties: Nelson, Washington

Profession: Self-employed

Religious Affiliation: Catholic

Birthday: Sept 20

Education: Bellarmine College, BA

Legislative Service: House 1980-1992

Committee Assignments: Rules, Appropriations & Revenue,
Elections & Constitutional Amendments

KMA Key Contact: Charles B. Spalding, MD, Bardstown
(502) 348-5968 (O)

**DISTRICT 53****Ray Mullinix (R)**

208 Baker Street
Burkesville, KY 42717

(502) 433-7192 (O)
864-3881 (H)

Counties: Clinton, Cumberland, Russell,
Wayne

Profession: Broadcaster

Religious Affiliation: Baptist

Birthday: Sept 4

Education: Lindsey Wilson College

Legislative Service: House 1989-1992

Committee Assignments: State Government

KMA Key Contact: Samuel L. Rice, MD, Burkesville
(502) 864-5102 (O)

Joseph D. Skipworth, MD, Burkesville
(502) 864-3894 (O)

**DISTRICT 51****Ray H. Altman (R)**

PO Box 4009
Campbellsville, KY 42718

(502) 465-4218 (O)
465-7889 (H)

Counties: Green, Metcalf, Taylor

Profession: Insurance agent

Religious Affiliation: Methodist

Birthday: Nov 2

Education: Campbellsville College; U of
Alabama at Birmingham

Legislative Service: House 1987-1992

Committee Assignments: Banking & Insurance, Transportation

KMA Key Contact: Eugene H. Shively, MD, Campbellsville
(502) 465-2821 (O)

**DISTRICT 54****Philip Joseph Clarke (D)**

420 Boone Trail
Danville, KY 40422

(606) 236-2240 (O)
236-4064 (H)

Counties: Boyle, Lincoln

Profession: Attorney

Religious Affiliation: Catholic

Birthday: Mar 12

Education: Notre Dame U, BSCE;
Georgetown U, JD

Legislative Service: House 1970-1992

Committee Assignments: Appropriations & Revenue

KMA Key Contact: Scott B. Scutchfield, MD, Danville
(606) 236-8730 (O)



HOUSE

DISTRICT 55

Jack L. Coleman, Jr. (D)

365 Curdsville Road
Burgin, KY 40310
(606) 748-5211 (O)
748-5947 (H)

Counties: Anderson, Mercer, Spencer
Profession: Lumber yard owner
Religious Affiliation: Baptist
Birthday: Oct 1

Education: Eastern KY U
Legislative Service: House 1992
Committee Assignments:

KMA Key Contact: John S. Baughman, III, MD, Harrodsburg
(606) 734-5429 (O)



DISTRICT 58

Marshall Long (D)

PO Box 505
Shelbyville, KY 40065
(502) 633-3181 (O)
633-3621 (H)

Counties: Henry, Shelby
Profession: Businessman
Religious Affiliation: Presbyterian
Birthday: Oct 23

Education: Centre College, BA
Legislative Service: House 1982-1992

Committee Assignments: Appropriations & Revenue
KMA Key Contact: William Powers, MD, Shelbyville

(502) 633-4622 (O)
Ronald E. Waldrige, MD, Shelbyville
(502) 583-2300 (O)



DISTRICT 56

Joseph Howard Barrows (D)

152 Stout Avenue
Versailles, KY 40383
(606) 873-3341 (O)
873-9678 (H)

Counties: Franklin, Jessamine, Woodford
Profession: Attorney
Religious Affiliation: Methodist
Birthday: Apr 16

Education: DePauw U, BA; U of K, JD
Legislative Service: House 1980-1992

Committee Assignments: Appropriations & Revenue, State
Government, Judiciary

KMA Key Contact: Scott H. Zibell, MD, Versailles
(606) 873-8111 (O)



DISTRICT 59

James F. Zimmerman (R)

3404 Sycamore Road
LaGrange, KY 40031
(502) 241-4025 (H)

Counties: Oldham, Trimble
Profession: Manufacturer's
representative

Religious Affiliation: Methodist
Birthday: May 20

Education: Morehead State U, BA
Legislative Service: House 1989-1992

Committee Assignments: Rules

KMA Key Contact: Gordon T. McMurtry, MD, Prospect
(502) 589-2114 (O)



DISTRICT 57

C. M. Hancock (D)

514 Murray Street
Frankfort, KY 40601
(502) 227-2666 (O)
223-3662 (H)

County: Franklin
Profession: Businessman, insurance
agent

Religious Affiliation: Catholic
Birthday: Mar 3

Education: Bellarmine College, U Of K
Legislative Service: House 1974-1992

Committee Assignments: Appropriations & Revenue,
Transportation

KMA Key Contact: John P. Stewart, MD, Frankfort
(502) 227-4821 (O)



DISTRICT 60

Gex "Jay" Williams (R)

14142 Walton-Verona Road
Verona, KY 41092
(513) 579-0455 (O)
(606) 485-4438 (H)

County: Boone
Profession: Computer software
executive

Religious Affiliation: Christian
Birthday: Aug 22

Education: U.S. Naval Academy, BS, MS
Legislative Service: House 1992

Committee Assignments: Elections & Constitutional Amendments,
Health & Welfare

KMA Key Contact: (to be announced)



DISTRICT 61**Clay Crupper (D)**

25 Wilorn Drive
 Dry Ridge, KY 41035
 (606) 823-7051 (H)
 Counties: Carroll, Gallatin, Grant, Owen
 Profession: Milk-hauler, farmer
 Religious Affiliation: Baptist
 Birthday: Oct 12
 Education: Eastern Kentucky U
 Legislative Service: House 1974-1992
 Committee Assignments: Business Organizations & Professions
 KMA Key Contact: Michael Goodman, MD, Williamstown
 (606) 824-5061 (O)

**DISTRICT 64****Thomas Robert Kerr (D)**

5415 Old Taylor Mill Road
 Taylor Mill, KY 41015
 (606) 431-2222 (O)
 356-1344 (H)
 Counties: Kenton, Pendleton
 Profession: Attorney
 Religious Affiliation: Baptist
 Birthday: July 25
 Education: U of K, BBA; Chase College of Law, JD
 Legislative Service: House 1985-1992
 Committee Assignments: Rules, Judiciary
 KMA Key Contact: David W. Suetholz, MD, Taylor Mill
 (606) 491-2855 (Taylor Mill) (O)
 431-6828 (Scott St) (O)

**DISTRICT 62****Mark Farrow (D)**

2785 Stamping Ground Road
 Stamping Ground, KY 40379
 (502) 863-6288 (O)
 535-6104 (H)
 Counties: Harrison, Scott
 Profession: Banker, attorney
 Religious Affiliation: Baptist
 Birthday: Apr 13
 Education: Georgetown College; Kentucky State U, BA; Chase
 College of Law, JD
 Legislative Service: House 1980-1992
 Committee Assignments: Banking & Insurance
 KMA Key Contact: Fred T. Tuttle, MD, Georgetown
 (502) 863-5994 (O)
 Sudhideb Mukherjee, MD, Georgetown

**DISTRICT 65****Martin J. Sheehan (D)**

310 View Place
 Ludlow, KY 41016
 (606) 261-3200 (O)
 254-3681 (H)
 County: Kenton
 Profession: Attorney
 Religious Affiliation: Catholic
 Birthday: Oct 26
 Education: Northern Kentucky U, BA;
 Chase College of Law, JD
 Legislative Service: House 1989-1992
 Committee Assignments: Business Organizations & Professions,
 Elections & Constitutional Amendments, State Government
 KMA Key Contact: Alvin C. Poweleit, MD, Covington
 (606) 581-4844 (O)

**DISTRICT 63****Kenneth F. Harper (R)**

2700 Main Chase
 Crestview Hills, KY 41017
 (606) 341-1270 (O)
 341-1275 (H)
 County: Kenton
 Profession: Realtor
 Religious Affiliation: Catholic
 Birthday: Jan 15
 Education: U of K
 Legislative Service: House 1964-1968, 1982-1992
 Committee Assignments: Appropriations & Revenue, Elections &
 Constitutional Amendments
 KMA Key Contact: Lee C. Hess, MD, Florence
 (606) 371-1153 (O)

**DISTRICT 66****H. Lawson Walker, II (R)**

Suite 430 7300 Turfway Road
 Florence, KY 41042
 (606) 283-0515 (O)
 341-9064 (H)
 Counties: Boone, Kenton
 Profession: Attorney
 Religious Affiliation: Christian
 Birthday: Feb 10
 Education: U of Cincinnati, BBA, JD
 Legislative Service: House 1987-1992
 Committee Assignments: Rules, Banking & Insurance, Judiciary
 KMA Key Contact: Charles F. Allnutt, MD, Edgewood
 (606) 344-2160 (O)



HOUSE

DISTRICT 67

James P. Callahan (D)

101 Bonnie Lynn Terrace
Southgate, KY 41071
(606) 441-7400 (O)
781-1232 (H)

Counties: Campbell, Kenton
Profession: Personnel/office manager
Religious Affiliation: Catholic
Birthday: Aug 21
Education: Thomas More College
Legislative Service: House 1987-1992
Committee Assignments: Business Organizations and Professions
KMA Key Contact: Robert E. Smith, MD, Covington
(606) 431-3748 (O)



DISTRICT 70

Pete Worthington (D)

RR 1, Box 131
Ewing, KY 41039
(606) 232-3034 (O)
267-3281 (H)

Counties: Bracken, Fleming, Mason, Robertson
Profession: Mechanical engineer, farmer
Religious Affiliation: Baptist
Birthday: Dec 5
Education: Morehead State U, BS;
U of K, BS-ME
Legislative Service: House 1978-1992
Committee Assignments: Rules, Appropriations & Revenue, State Government, Transportation
KMA Key Contact: Glenn R. Womack, MD, Flemingsburg
(606) 849-2323 (O)



DISTRICT 68

William I. Donnermeyer (D)

333 Bonnie Leslie Avenue
Bellevue, KY 41073
(606) 441-5854 (H)
Counties: Bracken, Campbell, Pendleton
Profession: Pipefitter
Religious Affiliation: Catholic
Birthday: Sept 19

Education: Villa Madonna College
Legislative Service: House 1970-1992
Committee Assignments: Rules, Business Organizations & Professions, Health & Welfare
KMA Key Contact: William B. Monnig, MD, Edgewood
(606) 341-2672 (O)



DISTRICT 71

Walter Blevins, Jr., DMD (D)

1024 Gregory Court
Morehead, KY 40351
(606) 743-1212 (O)
783-1388 (H)

Counties: Lawrence, Lewis, Morgan, Rowan
Profession: Dentist
Religious Affiliation: Baptist
Birthday: Mar 29
Education: Morehead State U, BS;
U of K College of Dentistry, DMD
Legislative Service: House 1982-1992
Committee Assignments: Appropriations & Revenue, Health & Welfare
KMA Key Contact: (to be announced)

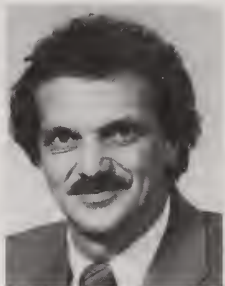


DISTRICT 69

Jon David Reinhardt (R)

637 West Poplar Thicket Road
Alexandria, KY 41001
(513) 397-6303 (O)
(606) 635-3455 (H)

Counties: Campbell, Pendleton
Profession: Manager, realtor, businessman
Religious Affiliation: Baptist
Birthday: Apr 1
Education: U of K; U of Cincinnati
Legislative Service: House 1984-1992
Committee Assignments: Business Organizations & Professions
KMA Key Contact: Fred A. Stine, MD, Highland Heights
(606) 441-7600 (O)



DISTRICT 72

Jim LeMaster (D)

1400 Vine Center Tower
Lexington, KY 40593
(606) 231-8500 (O)
987-7873 (H)

Counties: Bourbon, Fayette
Profession: Attorney, businessman
Religious Affiliation: Baptist
Birthday: Aug 12
Education: U of K, BA, JD
Legislative Service: House 1976-1992
Committee Assignments: Appropriations & Revenue
KMA Key Contact: David A. Hull, MD, Lexington
(606) 252-5691 (O)



DISTRICT 73**Paul W. Richardson (D)**

72 Milwood
Winchester, KY 40391
(606) 744-6565 (H)
Counties: Clark, Powell
Profession: Banker
Religious Affiliation: Christian
Birthday: Dec 23
Legislative Service: House 1976-1992
Committee Assignments: Banking &
Insurance, Transportation
KMA Key Contact: Harold S. Moberly, Jr., MD, Winchester
(606) 744-2732 (O)

**DISTRICT 76****Ruth Ann Palumbo (D)**

10 Deepwood Drive
Lexington, KY 40505
(606) 299-2597 (H)
County: Fayette
Profession: Community Volunteer
Religious Affiliation: Baptist
Birthday: July 7
Education: U of K, BA
Legislative Service: House 1992
Committee Assignments: Business Organizations & Professions,
Health & Welfare
KMA Key Contact: Preston P. Nunnolley, MD, Lexington
(606) 278-6096 (O)

**DISTRICT 74****Adrian K. Arnold (D)**

3589 Aaron's Run Road
Mt. Sterling, KY 40353
(606) 498-3034 (H)
Counties: Bath, Montgomery, Nicholas
Profession: Farmer
Religious Affiliation: Christian
Birthday: Apr 27
Education: Morehead State U
Legislative Service: House 1974-1992
Committee Assignments:
KMA Key Contact: (to be announced)

**DISTRICT 77****Louie Mack (D)**

271 Burke Road
Lexington, KY 40511
(606) 252-7872 (H)
County: Fayette
Profession: Retired educator
Religious Affiliation: Baptist
Birthday: Nov 28
Education: Transylvania U, AB; U of K, MA
Legislative Service: House 1985-1992
Committee Assignments: Elections & Constitutional Amendments,
Health & Welfare
KMA Key Contact: Vernon F. Hart, MD, Lexington
(606) 299-6223 (O)

**DISTRICT 75****Ernesto Scorsone (D)**

804 First National Building
167 West Main
Lexington, KY 40507
(606) 254-5766 (O)
254-3681 (H)
County: Fayette
Profession: Attorney
Religious Affiliation: Catholic
Birthday: Feb 15
Education: U of K, BA, JD
Legislative Service: House 1985-1992
Committee Assignments: Appropriations & Revenue, Health &
Welfare
KMA Key Contact: John W. Garden, MD, Lexington
(606) 277-1129 (O)

**DISTRICT 78****Pat Freibert (R)**

659 Tateswood Drive
Lexington, KY 40502
(606) 269-1279 (H)
County: Fayette
Profession: Civic activist
Religious Affiliation: Catholic
Birthday: June 8
Education: West Virginia Tech, BA
Legislative Service: House 1979-1992
Committee Assignments: Health & Welfare
KMA Key Contact: Russell L. Travis, MD, Lexington
(606) 277-6143 (O)



HOUSE

DISTRICT 79

William M. Lear, Jr (D)

732 Lakeshore Drive
Lexington, KY 40502

(606) 231-3000 (O)

269-4852 (H)

County: Fayette

Profession: Attorney

Religious Affiliation: Presbyterian

Birthday: June 26

Education: Davidson College, BA; U of K

College of Law, JD

Legislative Service: House 1985-1992

Committee Assignments: Business Organizations & Professions,
State Government

KMA Key Contact: John R. Allen, MD, Lexington

(606) 253-0142 (O)



DISTRICT 82

Jo Elizabeth Bryant (R)

North 10th

Williamsburg, KY 40769

(606) 549-4987 (H)

Counties: McCreary, Whitley

Profession: Legislator

Religious Affiliation: Baptist

Birthday: Aug 6

Education: Cumberland College, AD; St.

Joseph Hospital School of Medical Technology

Legislative Service: House 1992

Committee Assignments: Elections & Constitutional Amendments,
Judiciary

KMA Key Contact: Don C. Barton, MD, Corbin

(606) 528-2124 (O)



DISTRICT 80

Danny R. Ford (R)

PO Box 1245

Mt. Vernon, KY 40456

(606) 256-5229 (O)

256-4446 (H)

Counties: Lincoln, McCreary, Pulaski,
Rockcastle

Profession: Auctioneer, realtor

Religious Affiliation: Baptist

Birthday: Apr 25

Education: Eastern Kentucky U, BS

Legislative Service: House 1982-1992

Committee Assignments: Appropriations & Revenue, Business
Organizations & Professions, State Government

KMA Key Contact: James D. Crase, MD, Somerset

(606) 679-9268 (O)



DISTRICT 83

Thomas W. Todd (R)

Route 2

Nancy, KY 42554

(606) 679-3179 (O)

636-6124 (H)

Counties: Pulaski, Russell

Profession: Building contractor

Religious Affiliation: Methodist

Birthday: Aug 13

Legislative Service: House 1982-1992

Committee Assignments: Health & Welfare

KMA Key Contact: James D. Crase, MD, Somerset

(606) 679-9268 (O)



DISTRICT 81

Harry Moberly, Jr (D)

PO Box 721

Richmond, KY 40475

(606) 622-1501 (O)

624-2781 (H)

County: Madison

Profession: Attorney

Religious Affiliation: Protestant

Birthday: Sept 2

Education: Eastern Kentucky U, BA;

U of L, JD

Legislative Service: House 1980-1992

Committee Assignments: Appropriations & Revenue

KMA Key Contact: William G. Clouse, MD, Richmond

(606) 623-2940 (O)



DISTRICT 84

Clarence D. Noland, Jr (R)

PO Box 364

Irvine, KY 40336

(606) 723-2254 (H)

Counties: Estill, Jackson, Lee, Menifee,
Powell

Profession: Locomotive engineer, farmer

Religious Affiliation: Protestant

Birthday: June 11

Legislative Service: House 1982-1992

Committee Assignments: Appropriations & Revenue, Rules

KMA Key Contact: Charles E. Terry, MD, Irvine

(606) 723-2167 (O)



DISTRICT 85**Tom Jensen (R)**

303 South Main Street
London, KY 40741
(606) 878-8845 (O)
864-9772 (H)

County: Laurel

Profession: Attorney

Religious Affiliation:

Birthday: Dec 29

Education: Cumberland College, BS; Northern Kentucky U; Chase College of Law, JD

Legislative Service: House 1984-1986, 1989-1992

Committee Assignments: Rules, State Government

KMA Key Contact: Paul R. Smith, MD, London

(606) 878-8845 (O)

William D. Pratt, MD, London

(606) 864-6001 (O)

**DISTRICT 88****Roger Noe (D)**

111 North 3rd Street
Harlan, KY 40831
(606) 589-2145 (O)
573-9456 (H)

County: Harlan

Profession: Professor

Religious Affiliation: Baptist

Birthday: May 14

Education: Cumberland College, BS;
Eastern Kentucky U, MA; U of K, PhD

Legislative Service: House 1978-1992

Committee Assignments: Appropriations & Revenue

KMA Key Contact: J. D. Miller, MD, Evarts

(606) 837-2108 (O)

Jerry M. Bryson, MD, Harlan

(606) 573-4520 (O)

**DISTRICT 86****Tom O'Dell Smith (R)**

Route 1, Box 338
Gray, KY 40734
(606) 546-8015 (O)
546-4040 (H)

Counties: Clay, Knox

Profession: Businessman

Religious Affiliation: Baptist

Birthday: Nov 20

Education: Cumberland College

Legislative Service: House 1984-1992

Committee Assignments: Banking & Insurance, Health & Welfare

KMA Key Contact: Donald C. Barton, MD, Corbin

(606) 528-2124 (O)

**DISTRICT 89****Jim Maggard (D)**

Jetts Drive
Jackson, KY 41331
(606) 439-0029 (O)
666-4495 (H)

Counties: Breathitt, Magoffin, Wolfe

Profession: Public relations

Religious Affiliation: Baptist

Birthday: Oct 16

Education: Graduate, Career School of Broadcasting

Legislative Service: House 1982-1992

Committee Assignments: Rules, Transportation

KMA Key Contact: Robert E. Cornett, MD, Jackson

(606) 666-5103 (O)

**DISTRICT 87****Michael Dean Bowling (D)**

Number 3, Edgewood Court
Middlesboro, KY 40965
(606) 248-4666 (O)
248-8660 (H)

Counties: Bell, Whitley

Profession: Attorney

Religious Affiliation: Methodist

Birthday: Feb 27

Education: U of K, BA; Chase College of Law, JA

Legislative Service: House 1992

Committee Assignments: Judiciary, Transportation

KMA Key Contact: Talmadge V. Hays, MD, Pineville

(606) 337-7002 (O)

**DISTRICT 90****Stephen C. Keith (R)**

Route 8, Box 216
Manchester, KY 40962
(606) 598-5313 (O)
598-6538 (H)

Counties: Clay, Jackson, Leslie, Owsley

Profession: School social worker

Religious Affiliation: Baptist

Birthday: Oct 16

Education: Cumberland College, BS;
Eastern Kentucky U, MA

Legislative Service: House 1985-1992

Committee Assignments: Business Organizations & Professions,
Transportation

KMA Key Contact: William E. Becknell, Jr, MD, Manchester

(606) 598-5114 (O)



HOUSE

DISTRICT 91

Paul Mason (D)

380 Hazard Road
Whitesburg, KY 41858
(606) 633-4961 (O)
633-0415 (H)

Counties: Letcher, Perry, Pike
Profession: Automobile dealer
Religious Affiliation: Presbyterian
Birthday: July 5

Education: Alice Lloyd College, AA;
U of L, Pikeville College

Legislative Service: House 1987-1992

Committee Assignments: Appropriations & Revenue,
Health & Welfare

KMA Key Contact: William M. Collins, MD, Whitesburg
(606) 633-4488 (O)



DISTRICT 94

Herbert Deskins, Jr (D)

Box 1199
Pikeville, KY 41501
(606) 437-6206 (O)
432-3414 (H)

County: Pike
Profession: Attorney, farmer,
businessman

Religious Affiliation: Church of Christ

Birthday: Nov 26

Education: U of K, JD

Legislative Service: House 1976-1992

Committee Assignments: Banking & Insurance, Judiciary

KMA Key Contact: Harvey A. Page, MD, Pikeville
(606) 432-2872 (O)



DISTRICT 92

Russell O. Bentley (D)

HC 80, Box 3020
Topmost, KY 41862
(606) 447-2439 (H)

Counties: Floyd, Knott, Letcher
Profession: Merchant, businessman
Religious Affiliation: Baptist
Birthday: Sept 19

Education: Eastern Kentucky U, BBA

Legislative Service: House 1989-1992

Committee Assignments: Appropriations & Revenue

KMA Key Contact: (to be announced)



DISTRICT 95

Gregory D. Stumbo (D)

Fred's Fork
Prestonsburg, KY 41653
(606) 285-9228 (O)
886-9953 (H)

County: Floyd

Profession: Attorney

Religious Affiliation: Baptist

Birthday: Aug 14

Education: U of K, BA; U of L, JD

Legislative Service: House 1980-1992

Committee Assignments: Rules

KMA Key Contact: James D. Adams, MD, Prestonsburg
(606) 886-8552 (O)



DISTRICT 93

N. Clayton Little (D)

HC 83, Box 385
Virgie, KY 41572
(606) 639-4048 (O)
639-4694 (H)

County: Pike

Profession: Educator, businessman

Religious Affiliation: Baptist

Birthday: June 9

Education: Pikeville College, BS; Eastern Kentucky U, MA;
Morehead State U

Legislative Service: House 1974-1992

Committee Assignments: Labor & Industry, Transportation,
Elections & Constitutional Amendments

KMA Key Contact: Samuel J. King, MD, Pikeville
(606) 432-1403 (O)



DISTRICT 96

Walter Gee (R)

Route 1, Hitchins Road
Grayson, KY 41143
(606) 474-5489 (H)

Counties: Carter, Greenup, Lewis

Profession: Hardware Store Owner

Religious Affiliation: Protestant

Birthday: Dec 28

Education: KY School of Embalming

Legislative Service: House 1992

Committee Assignments: Labor & Industry

KMA Key Contact: Paul R. Lewis, MD, Olive Hill
(606) 286-4441 (O)



DISTRICT 97**Hubert Collins (D)**

Route 276, Box 1140
Wittensville, KY 41274

(606) 297-3152 (H)

Counties: Johnson, Martin

Profession: Car dealer, real estate broker,
teacher

Religious Affiliation: Protestant

Birthday: Aug 19

Education: Morehead State U, BA, MA

Legislative Service: House 1992

Committee Assignments: Labor & Industry, Transportation

KMA Key Contact: Jerry D. Fraim, MD, Paintsville
(606) 789-3578 (O)

**DISTRICT 99****Rocky Adkins (D)**

PO Box 688

Sandy Hook, KY 41171

(606) 928-3433 (O)

738-4242 (H)

Counties: Boyd, Elliott, Lawrence

Profession: Coal firm employee

Religious Affiliation: Baptist

Birthday: Nov 4

Education: Morehead State U,

Undergraduate Bachelor of University Study,

Masters in Secondary Education

Legislative Service: House 1987-1992

Committee Assignments: Labor & Industry

KMA Key Contact: Patrick J. Serey, MD, Morehead
(606) 784-7551 (O)

**DISTRICT 98****Ronald R. Cyrus (D)**

1410 Cyrus Court

Flatwoods, KY 41139

(502) 695-6172 (O)

(606) 836-8644 (H)

County: Greenup

Profession: Executive Secretary &
Treasurer, KY AFL-CIO

Religious Affiliation: Pentecostal

Birthday: July 10

Education: Ashland Community College, AA; U of K

Legislative Service: House 1976-1992

Committee Assignments: Transportation, Elections &

Constitutional Amendments, Labor & Industry

KMA Key Contact: (to be announced)

**DISTRICT 100****Donald B. Farley (R)**

3208 Hackworth Street

Ashland, KY 41101

(606) 325-0034 (H)

Counties: Boyd, Greenup

Profession: Steel corporation executive

Religious Affiliation: Baptist

Birthday: Oct 25

Education: Eastern KY U; Marshall U

Legislative Service: House 1992

Committee Assignments: Labor & Industry

KMA Key Contact: (to be announced)



Note: We have listed under "Committee Assignments" only those committees where legislative proposals of interest to the medical profession are assigned.

Note also that Jefferson County maintains a Delegation Office during the Legislative Session. That phone number is (502) 583-0569.

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John Rogers, Somerset
Art Schmidt, Cold Spring

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Charlie Borders, Russell
Dan Kelly, Somerset
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Gerald Neal, Louisville
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Dan Seum, Louisville
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NOTE: The above-listed committees are those to which health and medical issues are generally referred.

1992 KENTUCKY GENERAL ASSEMBLY LEADERSHIP

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Assistant President Pro Tem	Charles W. Berger

PARTY LEADERS

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Caucus Chairman	David K. Karem
Whip	Greg Higdon

Republicans

Floor Leader	John D. Rogers
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Whip	Tom Buford

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Democrats

Floor Leader	Gregory D. Stumbo
Caucus Chairman	Jody Richards
Whip	Kenny Rapier

Republicans

Floor Leader	Tom Jensen
Caucus Chairman	Clarence Noland
Whip	Jim Zimmerman

LEGISLATIVE TERMS AND DEFINITIONS

The following terminology may be helpful to you in your involvement with legislative process.

Acts—the volume of bills enacted at one session; published by Legislative Research Commission

Adjourn (motion to)—an action to discontinue proceedings for the day; a privileged motion non-debatable, not subject to amendment, and requiring for its adoption the assenting votes of a majority of the members present and voting

Adjournment Sine Die—adjournment “without a day”; this action ends a session, since no time is set for reconvening; this type of adjournment may occur at any time during a session

Administrative regulation—an enactment of law by an executive-branch agency or department, under authority granted by the General Assembly.

Administration bill—legislation introduced at the behest of an executive-branch agency or department, usually sponsored by the majority floor leader

Adoption—approval or acceptance; usually applied to resolutions or amendments

Amend (motion to)—an action to modify the contents of a bill or question under consideration; the motion to amend is in order at any time prior to final passage, unless the previous question has been ordered

Amendment—any alteration made or proposed to be made in a bill, motion or clause thereof, by adding, substituting or deleting

Committee—a group of legislators, usually members of the same house, assigned to consider some issue or question and submit a report on its recommendations for action by the body which created it

Committee amendment—an amendment to a bill which is attached to the bill by a committee and made a part of the committee’s report on the bill

Conference Committee—a joint committee of senators and representatives directed to reach agreement on legislation on which the two houses are unable to agree

Committee, interim joint—a committee composed of all members of a Senate standing committee and all members of a House standing committee, which meets between sessions as a subcommittee of the Legislative Research Commission

Committee substitute—a bill offered by a committee in lieu of a bill it has considered; technically, the committee substitute is an amendment to the original bill

Companion bill—a bill which is identical to a bill having been introduced in the opposite house

Concur—action by one house to agree to modifications of its legislation by the opposite house

Consent calendar (or consent orders)—a list of bills having had one (or two) reading(s), and on which members in attendance are presumed to vote yes unless they indicate a negative vote prior to the call of the roll

Constitutional majority—one more than half of the members of deliberative body

Co-sponsor—a sponsor of a bill or resolution who is not the principal sponsor

Effective date—the date on which a legislative measure begins to function as a part of the law; in Kentucky, most legislation becomes effective 90 days after sine die adjournment

Emergency clause—provision in a bill that it become effective immediately upon approval by the governor rather than the 90 days after adjournment

Enrollment—the act of comparing a printed bill to be transmitted to the governor with the original; introduced bill with all amendments, so as to ascertain their identical form

Floor—the area of a legislative chamber which is occupied by the members and staff of the body

Floor amendment—an amendment filed with the clerk to be considered on third reading of the bill to which it has been filed

General orders—a list of measures eligible for debate, amendment and voting on a given day, without reference to a particular time of day or place in the order of business

Hopper—colloquial name given the repository for bills awaiting introduction; in Kentucky such bills are filed with the clerk

House—one body of deliberation in a legislature; customarily a shortened name for the House of Representatives

Interim—the period of time between sessions of a legislature

Introduction—the presentation of a bill or resolution to the legislative body for its consideration

Joint sponsorship—a procedure in the Kentucky House of Representatives whereby several members may sponsor legislation without one being a “principal” sponsor, and each bearing equal responsibility as endorsing the measure

Kentucky Revised Statutes—the official title of statute law in Kentucky; each bill creates, amends, or repeals a section of the KRS

Lay on the clerk’s desk (motion to)—an action to place a measure in a position of temporary postponement

Lay on the table (motion to)—an action to declare a measure defeated

Majority caucus chairman—a member affiliated with the majority party, who is responsible for convening the caucus of his party and presiding over its deliberations

Majority floor leader—a member affiliated with the majority party, designated to act for the party during the proceedings on the floor

Majority party—the political party whose members occupy at least one more than half of the total membership of the body

Majority whip—a member affiliated with the majority party, designated to assist the floor leader during proceedings on the floor

Passage—the approval of a bill or resolution by way of an affirmative vote

Postpone indefinitely (motion to)—action to prevent consideration of a measure for the remainder of the session, unless a constitutional majority sustains a motion to reconsider the matter

Postpone to a fixed time (motion to)—to defer consideration of a question until a time specified in the motion

Prefiled bill—a bill filed prior to the session, for public discussion and printing

President—the presiding officer in the Senate

President pro tempore—the Senator, elected by the Senate, chosen to preside in lieu of the President when such officer is absent or unable to preside

Quorum—the number of members of a legislative body which must be present to transact business

Reading—each bill to be enacted in Kentucky must have three readings, at length, in each house

Recommit (motion to)—action to send a measure to committee after it has been previously reported

Reconsider (motion to)—action to re-take a vote; the motion may be offered only by a member having voted previously on the prevailing side

Refer—to send a measure or question to committee

Resolution, concurrent—expression of opinion or request by both houses of a legislature, without the force of law

Resolution, joint—to enact matters of law not to be made a portion of the statutes

Resolution, simple—expression or request by one house

Revision—the process of inserting the enactments of a session into existing statute law

Roll call—to determine a vote on a question by taking of names in favor and opposed

Section—a division of a bill or statute, separated according to topic covered or action taken

Session, extraordinary—a session convened by call of the Governor

Session, regular—a session convened on a regular basis by way of constitutional provision as to its date and length

Simple majority—a majority of those voting on a question

Speaker—the presiding officer of the House of Representatives

Speaker pro tempore—the member of the House of Representatives selected to preside in the absence or inability of the Speaker

Special order—an action predetermined to occur at a specific time on a specific date

Stopping the clock—an occasional tactic on the final evening of a regular session whereby the proceedings continue into the following day, with the clock and journal continuing to indicate occurrences of action of the preceding day

Sunset legislation—a law requiring termination of a particular agency or program on a predetermined date, unless justification for continuance is presented to the legislature prior to such occurrence

Suspend the rules—action to negate the application of a particular rule of procedure; the rule and purpose must be stated in the motion to suspend

Veto—rejection of an enactment without authority to modify; usually the prerogative of the Governor

Veto override—authority of the legislature to overturn a rejection of legislation by the Governor

Voice vote—a method of voting whereby only a vocal response to a question is indicated

Vote—a decision on a question by a member of a deliberative body, either affirmative or negative

Withdraw—to recall, remove or delete a question from consideration

PROFESSIONAL LIABILITY ISSUES



MEDICAL LIABILITY —

A History of Legislation in Kentucky

During the mid-1970s, Kentucky, like many other states, was caught in a medical liability crisis. The market for professional liability coverage began to shrink. If coverage was available its price was prohibitive.

When the General Assembly convened in 1976, Kentucky Legislators were acutely aware of the problem. A special task force appointed by the Governor had studied the situation for months. Also, a great deal of publicity and legislative activity occurred during 1975 when most state legislatures were meeting.

Kentucky's General Assembly responded in 1976 by passing legislation which:

- Eliminated the Ad damnum clause.
- Provided that an advance payment could not be used as evidence to show admission of liability on the part of the physician or the insurance carrier.
- Adopted the Statute of Frauds, allowing no liability for guarantees unless submitted to the patient in writing.
- Codified informed consent into law.
- Ensured the confidentiality of peer review.
- Established a patient compensation fund, requiring all physicians and hospitals to belong.
- Created a joint underwriting association for providers to obtain coverage.
- Required reporting of all claims, settled or adjudicated, to the state Insurance Commissioner.

In 1977, the Kentucky Supreme Court ruled that provisions relating to the creation and maintenance of the Patient's Compensation Fund were unconstitutional. The Court also declared that the amendment establishing peer review confidentiality was unconstitutional because the amendment was not germane to the title of the enacting legislation.

The 1978 General Assembly re-enacted legislation regarding peer review confidentiality.

In 1978, the Kentucky Medical Association founded the Kentucky Medical Insurance Company. Today, it insures approximately 50% of Kentucky's practicing physicians.

In 1980, the liability crisis reappeared, and KMA sought legislative relief from the 1986 General Assembly. The KMA supported legislation to limit awards, limit noneconomic awards, reduce statute of limitations for minors, and establish periodic payments. None of the KMA-supported measures were passed.

In 1988, the KMA joined with over 20 professional and business organizations to present legislation to resolve the liability crisis. The legislation included proposals to modify the tort system and strengthen insurance laws and regula-

tions. **House Bill 551** included the following tort reforms relating to physicians liability claims:

• **Joint and Several Liability**

Requires that juries be instructed to determine the percentage of fault appropriate to each claimant, defendant, third party defendant and defendants settling out of court and then apportion each party's "equitable share . . . in accordance with the respective percentages of fault."

• **Standards of Conduct for Punitive Damages**

In suits for punitive damages, the standard of evidence should be "clear and convincing" rather than based upon a "preponderance of evidence"; and the conduct involved must constitute oppression, fraud, or malice as defined in the proposal.

• **Collateral Source Rule**

Requires plaintiffs or their attorney to notify all parties known to have subrogation rights that an action has been filed. If the party with subrogation rights fails to intervene, those subrogation rights are lost. Further, the jury would be advised of the existence of collateral source payments, the amount paid by or on behalf of the plaintiff for such benefits, and the known subrogation rights of the collateral payors. The jury would then decide whether or not to offset the total award by the amount already paid by such sources.

• **Standards of Conduct for Officers and Directors of For-Profit Corporations and Officers, Directors, and Volunteers of Non-Profit Corporations and Charitable Organizations**

Adopts standards of conduct and duties for officers and directors, and establishes that monetary damages may be awarded only upon "clear and convincing" evidence that the conduct was "willful, wanton or in reckless disregard" of the interests of the corporation or its shareholders. These provisions define standards of conduct for which officers and directors could not be held personally liable.

• **Confidentiality of Peer Review Records**

Amends the Medical Practice Act to clarify questions of confidentiality and liability of individuals participating in the medical peer review process.

• **Antitrust Immunity for Peer Review and Centralized Reporting of Liability Claims**

Adopts provisions of the Health Care Quality Improvement Act of 1986 which established immunity from antitrust claims for good faith peer review; also establishes centralized reporting of malpractice and disciplinary actions.

House Bill 552 included numerous reforms of the insurance industry relating to physician liability insurance, as follows:

- **Assures Availability of Insurance**

All insurers licensed to write property and casualty insurance in Kentucky participate in the FAIR plan (fair access to insurance requirements) and pay assessments to the plan based upon a percentage of premiums voluntarily written in Kentucky. Amendments allow the Commissioner, if reasonable competition did not exist for certain lines of insurance, to amend the plan to provide insurance for those lines. An assessment of the participants would fund the program.

- **Extends Notification for Cancellation and Non-Renewal of Insurance**

Amends the statutory limitations (then 30 days) to require at least 75 days notice of intent to cancel or not renew property and casualty insurance.

- **Flex Rating Approaches**

Establishes a flex rating system whereby rates could not increase or decrease by more than 25 percent without filing the rates and obtaining prior approval from the Commissioner.

- **Closed Claim Information**

Requires state government to gather information on insurance claims and civil litigation to determine now and for the future the extent and nature of problems. Requires the insurance industry to provide information to the Commissioner of Insurance who would annually compile the information and submit a report to the Governor and General Assembly.

- **Kentucky Claims Experience**

Requires insurers to annually provide to the Commissioner of Insurance information which would identify to what extent Kentucky's experience is being used in determining rates charged in Kentucky.

- **Insurance Settlement**

Assists insureds by requiring insurers to settle claims within a reasonable time and manner. Failure to act accordingly could result in the company paying interest as well as attorney fees.

- **Unfair Claims Settlement Practices Act**

Gives consumers of insurance the benefit of the Act, upon any violation, and recommends that the Commissioner be permitted to reprimand or fine a violator for a single violation of the Act.

- **Insurance Consumers' Advisory Council**

Creates an Insurance Consumers' Advisory Council to monitor the sale and pricing of insurance in Kentucky and recommends changes in the law to the Commissioner, Governor, and the General Assembly on behalf of the consumers of insurance. Permits the Advisory Council to review consumer complaints.

- **Increased Funding/Department of Insurance**

Requires increased regulatory responsibility be assumed by the Department and permits the Commissioner to assess insurers, to cover additional regulatory expenses. Permits the Department of Insurance to carry over funds and grants authority to set fees by regulation.

House Concurrent Resolution 62 was adopted by the General Assembly. These proposals were presented to the Kentucky Supreme Court for consideration.

- **Frivolous Lawsuits, Rule 11, and Certificates of Merit**

Recommends the Kentucky Supreme Court adopt a measure providing for a "certificate of merit."

- **Offer of Judgment**

Recommends to the Supreme Court of Kentucky that Civil Rule 68 be amended to provide greater incentives for its proper use.

- **Remittitur and Additur**

Recommends that the Supreme Court alter Civil Rules to allow the Court to review an award and to raise or lower it if the Court believes the amounts are excessive or inadequate.

KMA'S OBJECTIVES

KMA wants to reduce professional liability insurance premiums. It will help patients and their families, and will provide a more rational environment for the practice of medicine.

This is KMA's five-point program:

Primary:

- A **Constitutional Amendment** that would allow the General Assembly to place a limitation on non-economic awards.
- The Kentucky Medical Association supports implementation of a **Patient Compensation System**.

Secondary:

- An adjustment of the **Statute of Limitations** for Minors to avoid second-guessing physicians years after treatment.
- The establishment of **Periodic Payments** rather than lump sum payments.
- A **Neurologically Impaired Newborn Compensation Program**.

The crisis from which these recommendations grew is outlined in "The Liability Crisis" section which appears later in this publication.

In explanation of KMA's objectives, the following information is provided:

1. **Constitutional Amendment** — Section 54 of Kentucky's Constitution states, "The General Assembly shall have no power to limit the amount to be recovered for injuries resulting in death, or for injuries to person or property." Amending Kentucky's Constitution requires that the proposed amendment be agreed to by three-fifths of all members of the Kentucky General Assembly. Then such proposed amendment must be submitted to the voters of the State for their ratification or rejection at the next general election for members of the House of Representatives. If the amendment is approved by a majority of the voters, it shall become a part of the Constitution of the Commonwealth and be so proclaimed by the Governor. No more than four amendments shall be voted upon at any one time, and each proposed amendment shall be placed on the ballot in such manner that the electors shall be allowed to vote on each of such amendments separately. The approval of the Governor shall not be necessary to any proposed amendment to the Constitution.
2. **Patient Compensation System** — The Kentucky Medical Association supports implementation of a patient compensation system modeled after the Workers' Compensation System. The proposal would operate under the following tenets:
 - Patients injured in the health care system would receive reasonable compensation, regardless of fault.
 - Compensation would be paid by the health care provider except when the injury is the result of an inherent risk — previously identified and made known — of the

health care procedure being followed. Patients, however, have access to health and accident insurance to cover those risks.

Where the injury is due to some other cause, either negligence or an unknown cause, then the economic burden falls on the health care provider who has access to patients' compensation insurance to cover the risk. The procedure for determining reasonable compensation is similar to workers' compensation where medical costs and lost income are dealt with on an actual, as-occurring basis, and the claimant's legal fees are regulated.

3. **Statute of Limitations for Minors** — The basic Statute of Limitations provides that legal action be commenced within one year after the cause of action accrued. The statute specifies that the cause of action shall be deemed to accrue at the time the injury is first discovered, or in the exercise of reasonable care should have been discovered, provided that such action shall be commenced within five years from the date the alleged injury occurred. In the case of a minor, the Statute of Limitations will not begin to run until the individual reaches the age of majority, or 18 in Kentucky for medical liability claims.
4. **Periodic Payment of Future Damages** — Unless otherwise agreed upon by the parties involved or mandated by the court, judgments can be rendered only as a lump sum award. This type payment mechanism is frequently ill-suited to liability cases because awards in such cases often include payment for anticipated future medical care, lost earnings, inconvenience, and pain and suffering. Furthermore, the premature death of the claimant may create a windfall for the claimant's heirs where a significant portion of an award is based on future non-economic loss or damage. Under a periodic payment system, the payments are made over the actual lifetime of the claimant or for the actual period of disability. Under this system, funds are available for the purpose for which they were intended. The potential for a windfall upon the premature death of the claimant is eliminated, yet his heirs and dependents are assured of the continued payment of the portion of the judgment allocable to lost future earnings. An insurer can fund such periodic payments at substantially less cost than the equivalent lump sum payment. The savings can then be passed on in the form of lower liability insurance premiums, or a reduced rate of increase of such premiums, thus creating lower cost to the public for the services they want or require.
5. **Kentucky Perinatal Neurological Impairment Compensation Program** — KMA supports a plan to develop a schedule of payments for neurologically impaired newborns on either a no-fault or fault-based schedule of compensation. In the alternative, KMA supports development of a program to permit binding arbitration, to be signed prior to the institution of prenatal care, which would effectively allow and enforce this type of arrangement.

THE LIABILITY CRISIS

Liability Costs

The quality of health care and medical training in Kentucky continues to rise and benefit from technological breakthroughs.

But something's interfering with Kentuckians' ability to utilize this quality care. Particularly in rural areas, the patient's accessibility to such specialties as OB/GYN is disappearing.

A major part of the problem is the rising cost of malpractice liability insurance. Fourteen years ago one in 26 Kentucky doctors covered by Kentucky Medical Insurance Company (KMIC) had malpractice claims filed against them. In 1989, that figure had shot up to one in 12.

Consider this: The average medical malpractice award in Kentucky went from \$8,163 in 1982 to \$125,391 in 1989. KMIC records show that 38 cents of each dollar spent resolving those cases — the so-called "transactional costs" — went to the Kentucky patient. The other 62 cents were eaten up in the legal system.

And the patient gets stuck with the whole bitter pill.

What Happens to the Patient?

Patient and doctor share the burden of skyrocketing liability premiums.

Malpractice premiums for a family practitioner performing obstetrics, for example, averaged \$2,879 in 1984. In 1989, it was \$18,702. For OB/GYNs, the 1984 figure was \$9,182. In 1990 it rose to \$37,234. While costs of premiums have been somewhat alleviated, rising claims and increased jury awards signal the return of a cycle which occurs approximately every 10 years.

But the cost of health care service is only part of the picture. Availability of service is eroding because of the growing liability burden.

A Kentucky Medical Association survey showed that over the past 12 years, four out of five family-practice doctors in Kentucky have either stopped delivering babies or greatly reduced the amount of obstetrics practice and are spending more time on gynecological care. One of every eight Kentucky OB/GYNs has given up delivering babies altogether.

Some rural areas of Kentucky are hit especially hard. When doctors cease obstetrical care, patients have to drive to distant offices for care.

State officials also say this trend could have a major impact on Kentucky's Medicaid program, which covers the state's poorest residents.

Kentucky reflects a national trend. A survey conducted in 1987 by the American Academy of Family Physicians reported that 23.3% of family practice doctors who were delivering babies eight years ago had stopped offering obstetric care. An American College of Obstetrics and Gynecology survey

in 1985 showed that 86% of the nation's OB/GYNs had stopped doing or reduced their obstetrical work.

The College's survey also showed that Kentucky's OB/GYNs pay higher malpractice rates than their colleagues in some neighboring states. Kentucky's OB/GYNs paid an average of \$31,961 in premiums in 1987 compared to \$20,992 in Tennessee.

The Paying Public is Concerned About the Problem

From the trends just discussed, it's obvious that Kentucky physicians continue to be seriously concerned about the non-medical costs of delivering health care. But what about the public?

In 1987 KMA commissioned Hamilton, Frederick & Schneiders, a Washington, DC, research company, to address that question. They asked about consumer attitudes toward health care delivery costs, toward the legal system, toward the insurance industry, toward physicians and toward medical malpractice insurance rates. They also asked about the reform of liability laws relating to health care costs.

The key findings were these:

- Most Kentuckians are both aware of and concerned about high medical malpractice insurance rates impacting the cost of health care. A majority point to increasing malpractice insurance rates as the major cause of physician fee increases.
- Kentuckians support a wide range of solutions to the medical liability problem. As consumers, they see themselves as the most adversely affected group as malpractice rates have risen; they see physicians as the second most adversely affected group.
- A majority of Kentuckians blame the current legal system and its procedures for high malpractice rates. They feel that the system encourages needless lawsuits and higher settlements than justified.
- Kentuckians strongly support changes in the legal system to correct its ills. Specifically, they favor enacting a maximum cap of \$250,000 on jury awards for punitive or non-economic damages.
- The majority of Kentuckians feel that Kentucky insurance companies have raised malpractice coverage rates in response to the costs of providing the coverage.
- Kentuckians see both physicians and themselves as victims of increasing health care costs.

Some Steps Toward Curing the Problem

KMA supports reasonable awards in the case of true medical malpractice. That's not even at issue here. We're talking about the costs that both we and the public recognize have gone out of control.

We recommend this prescription:

- Constitutional change to allow the General Assembly to place a limitation on non-economic awards.
- A no-fault approach to medical malpractice/a patient compensation fund.
- Adjustment of the statute of limitations for minors.
- Establishment of periodic payments rather than lump sum payments.
- Neurologically impaired newborn compensation plan.

In 1976 the General Assembly passed a progressive package of legislation aimed at solving many of today's problems. But in 1977 the Kentucky Supreme Court ruled most of the package unconstitutional, including the crucial Patient Compensation Fund.

In 1988 the General Assembly responded to the liability crisis by adopting an excellent package of tort reform. We believe these reforms have had a positive influence on the liability insurance market, and additional reforms can provide tremendous savings in the health care field.

In 1990 KMA again supported a Constitutional Amendment to cap non-economic awards. While the proposal was not adopted, we will again seek support for this proposal in 1992.



MALPRACTICE

THE PUBLIC IS CONCERNED

THE PUBLIC IS CONCERNED. A survey of Kentuckians was conducted for KMA by a Washington, DC, firm. The major objectives of this study were to determine consumer attitudes toward:

- health care delivery costs;
- increases in medical malpractice insurance;
- the legal system, insurance industry and physicians;
- to identify support for reform of liability laws.

Key Findings were:

- Almost 90% of Kentuckians expressed the opinion that health care costs, in recent years, have gone up — nearly 60% feel costs have risen sharply.
- Most consumers are aware of the role malpractice insurance rates play in health care costs. A majority feel that rising insurance costs are a major factor in accelerating health care costs.
- The blame for high insurance rates falls squarely on the shoulders of the legal system, according to a majority of those surveyed. They feel the system encourages needless lawsuits and demands for unreasonable settlements.
- Kentuckians strongly support a wide range of solutions to the medical liability problem, which include: establishing a ceiling on jury awards for non-economic damages, assuring that a greater percentage of the jury awards goes to truly injured claimants rather than to the legal system, providing a vehicle to make out-of-court settlements easier, and enacting legislation to limit medical liability insurance rate increases.

We're not by ourselves in working for a solution to the critical liability problem in Kentucky.

The 1987 Kentucky Insurance and Liability Task Force finalized its report to the Kentucky General Assembly. The Task Force was created by resolution of the 1986 Regular Session of the General Assembly to study the insurance industry in Kentucky with special emphasis on the problems of availability and affordability of liability insurance. The Kentucky Medical Association was a primary proponent of the Resolution. Twenty-six members were appointed representing various interests in the Commonwealth affected by the "crisis," including attorneys (both plaintiff and defense), physicians, architects, engineers, cities, counties, insurers, insurance agents, child care providers, homebuilders, and business, as well as the Commissioner of Insurance and the Chairmen of the House and Senate Committees on Banking and Insurance.

The Kentucky Medical Association testified that physicians' rates had increased an average of 25% every year since 1981, which included a 44% increase in 1985, the same year in which premiums for excess coverage increased 135%. The number of underwriters for physician liability insurance decreased in five years from ten to two. KMA also testified that 28% of the OB/GYNs in Kentucky had stopped their OB prac-

tice altogether within the past eight years, and half of those had done so in the past year and a half.

The Task Force heard testimony from the Kentucky Medical Insurance Company on claims experience. KMIC, a physician-owned insurance company organized by KMA, insures nearly half of Kentucky's physicians. Carl L. Wedekind, Jr., LLB, President of KMIC (now retired) and a member of the Task Force, testified that from 1981 to 1984, KMIC had an average premium increase from 10% to 20%. In 1985, KMIC's premium increased 70%; in 1986, 27%; and for 1987 would increase 46%.

Mr Wedekind also presented a proposal for a no-fault medical malpractice insurance program. In addition, the Task Force received results of a survey on the insurance rate experience of Kentucky hospitals conducted by the Kentucky Hospital Association.

The Task Force met over 25 times in a one-and-a-half-year period, and Richard F. Hench, MD, a Past President of KMA, and Carl L. Wedekind, Jr., LLB, President of KMIC, served on the Task Force.

General Findings:

The Task Force found no evidence of a conspiracy on the part of the insurance industry to raise insurance rates during the "crisis" and found no banding together among insurers in restraint of trade.

The Task Force found no evidence or heard testimony that caused the members to conclude that there is a litigation explosion in Kentucky, although it does appear that in some areas, such as professional liability and product liability, claims have increased.

The Task Force was concerned with the tendency by Kentucky's court system to broaden opportunities for people to recover damages for a greater array of injuries, both economic and non-economic.

The Task Force believed that life itself poses risks and that persons who engage in certain activities expose themselves to certain risks and, as such, have no inherent right to recover the costs of suffering those risks from persons who are only indirectly responsible.

The Task Force believed that onerous regulation of insurance will cause insurers to leave the state for other markets. While these suggested recommendations for change may not result in an immediate reduction in insurance rates, the Task Force believed they will send a signal that Kentuckians want greater predictability and efficiency in the system. Finally, should Kentucky face a "crisis" again of this or lesser magnitude, these recommendations can offer relief by providing citizens alternative sources of insurance.

Recommendations:

The Task Force recommended the following:

1. **Joint and Several Liability**

The Task Force urged the General Assembly to adopt language which would require juries to be instructed to determine a percentage of fault to each claimant, defendant, third party defendant and defendants settling out of court and then determine each party's "equitable share . . . in accordance with the respective percentages of fault."

2. **Caps on Non-economic Damages and Section 54 of the Kentucky Constitution**

The Task Force recommended to the General Assembly the repeal or deletion of language contained in Section 54 of the Constitution. Section 54 provides that the Kentucky General Assembly shall have no power to limit the amount to be recovered for injuries resulting in death or from injuries to person or property.

3. **Abolish or Restrict Punitive Damages**

The Task Force recommended that in suits for punitive damages, the standard of evidence should be "clear and convincing" rather than based upon a "preponderance of evidence"; and the conduct involved must constitute oppression, fraud, or malice as defined in the proposal.

4. **Frivolous Lawsuits, Rule 11, and Certificates of Merit**

As an aid to Rule 11, the Task Force urged the General Assembly, or in the alternative the Kentucky Supreme Court, to adopt a measure providing for a "certificate of merit." Within 90 days of filing a lawsuit, the plaintiff or attorney would file with the court a certificate stating that the case has merit and that an expert witness will testify in support of the allegations. The attorney for the defense must also file a similar certificate. Failure to file the certificates by either party would serve as grounds for the court to dismiss the complaint or counterclaim.

5. **Offer of Judgment**

The Task Force recommended to the Supreme Court of Kentucky that Civil Rule 68 be amended to provide greater incentives for its proper use. By directing that all costs, including attorney fees, would be awarded against the party failing to accept a reasonable offer of settlement, the Task Force hoped that plaintiffs and defendants alike would avail themselves of the opportunity to evaluate the case and move expeditiously toward resolution before the parties incur substantial expenses often associated with litigation.

6. **Collateral Source Rule**

The Task Force rejected the idea of mandatory offset of collateral sources. The Task Force recommended that plaintiff or his attorney be required to notify all parties known to have subrogation rights that an action has been

filed. If the party with subrogation rights fails to intervene, those subrogation rights are lost. Further, the Task Force believed that the jury should be advised of all collateral sources so that it could decide whether or not to offset the total award by the amount already paid by such source.

7. **Structured Settlements or Periodic Payments**

The Task Force recommended that Courts require structured settlements for future wages, medical expenses, and pain and suffering where the amount allowable to such damage equals or exceeds ten times the annual state wage.

8. **Statute of Limitations for Minors**

The Task Force rejected a proposal to reduce the statute of limitations in Civil actions involving minors. Instead of allowing the statute to run until the age of majority, the rejected proposal would have given a minor under the age of 6 until his 8th birthday to bring an action.

9. **Increased Reporting of Medical Malpractice and Confidentiality of Peer Review Records**

The Task Force supported amendments to the Medical Practice Act which would clarify questions of confidentiality and liability of physicians participating in the peer review process. The Task Force did note that current law is sufficient regarding reporting of medical malpractice claims information.

10. **Remittitur and Additur**

The Task Force recommended altering Civil Rule 59.01 to allow the Court to review an award and to raise or lower it if the Court believes the amounts are excessive or inadequate.

11. **Patients' Compensation Plan**

The Task Force believed that the deteriorating situation on medical malpractice costs throughout the country is such that alternatives to the present system for settling medical malpractice disputes must be tried; and that Kentucky is in a position to be a leader in developing and implementing an alternate approach to a serious social problem.

The above-listed issues related to the medical malpractice problem. Important legislation relating to immunity for service on non-profit boards of directors and other service organizations was also addressed. In addition, the Task Force reviewed numerous other issues which have high priority with other businesses, organizations and professions.

The Commission on Constitutional Review, in 1987, concluded its section-by-section review of Kentucky's 98-year-

old Constitution and included in its report a recommendation that Section 54 of the Constitution be revised to allow the General Assembly power to limit the amount to be recovered for non-economic loss, punitive damages and all other non-pecuniary damage arising from injuries resulting in death or from injuries to person or property. The recommendation was to amend Section 54 to read as follows:

The General Assembly shall have no power to limit the amount to be recovered for economic loss, including medical expenses, property damage, and lost earnings arising from injuries to person or property. The General Assembly shall have the power to limit the amount to be recovered for non-economic loss, punitive damages and all other nonpecuniary damage arising from injuries resulting in death or from injuries to person or property. (Underlines indicate proposed added language.)

The HHS Task Force on Medical Liability was established partly in response to the presidential request that the US Department of Health and Human Services address the issue of medical liability and because of the Secretary's concern about the impact the liability situation is having on the quality and availability of health care in the United States. That Task Force, in its August 1987 final report, made recommendations which encompassed the four major objectives of KMA in dealing with the liability situation.

One of the most active proponents for change is the **Tort Reform Association of Kentucky (TRAK)**, a coalition of trade, business, professional and municipal organizations, whose goal is . . . "to effect long-term, meaningful reform of

Kentucky's civil justice system in order to make liability coverage available at affordable rates." While the organization's primary focus is tort reform, it is not a one-dimensional group. TRAK recognizes that the liability crisis has multiple causes and multiple solutions.

In addition to the Kentucky Medical Association, which provided start-up costs and administrative staff assistance, TRAK's members include the Associated General Contractors of Kentucky, Inc., Home Builders Association of Kentucky, Independent Insurance Agents of Kentucky, Inc., Jefferson County Medical Society, Kentucky Association of Health Care Facilities, Alliance of American Insurers, Kentucky Chamber of Commerce, Kentucky Dental Association, Kentucky Farm Bureau Insurance, Kentucky Grocers Association, Kentucky Hospital Association, Kentucky Medical Insurance Company, Kentucky Municipal League, Kentucky Nurses' Association, Kentucky Retail Federation, Kentucky Society of Architects, Kentucky Society of Certified Public Accountants, Kentucky Society of Professional Engineers, National Association of Independent Insurers, Keeneland Association, Kentucky Bankers Association, Kentucky OB-GYN — Kentucky Section of ACOG, Liberty National Bank, as well as Blue Cross and Blue Shield of Kentucky.

TRAK's proposal to the Kentucky Insurance and Liability Task Force recommended changes in the civil justice system, including limits on non-economic damages, reduction of the statute of limitations with regard to minors, periodic payment provisions, and offsets for collateral source payments.



1992 KMA LEGISLATIVE GOALS



1992 KMA LEGISLATIVE GOALS

Tort Reform

Primary:

- Constitutional Amendment to permit the General Assembly to place a limitation on non-economic awards;
- Implement a patient compensation or no-fault system.

Secondary:

- Adjust the statute of limitations for minors;
- Establish a periodic payments mechanism in lieu of lump sum payments;
- Adopt a neurologically impaired newborn compensation program.

Tobacco

The KMA opposes use of tobacco on school property and sale of tobacco products to individuals under 18. The Kentucky General Assembly is encouraged to increase cigarette taxes in order to discourage teenage smoking.

Certificate of Need

The KMA supports retention of the Certificate of Need Law, modification to present thresholds and the maintenance of the physician office exemption.

AIDS

The KMA supports legislation to:

- Prohibit discrimination against all persons infected with or perceived to be infected with HIV.
- Provide and make available anonymous testing for HIV.
- Appropriately confirm HIV positivity is reported to the Department for Health Services and the local health department including at least the person's date of birth, race, sex, risk factor(s), and county of residence. Identification can be by patient's name and address if patient agrees, but must include as a minimum a code assigned to the individual by the reporting physician which will always be the same for a given patient, but which in and of itself, will not identify the patient (such as patient's initials) by name.
- Assure that health care workers are informed of patients HIV status if directly responsible for care of the patient who has a sexually transmitted disease.
- Provide that consent for treatment by a physician or hospital shall also include the possibility of testing for HIV

if deemed appropriate by the physician(s) involved in the care of that patient.

Health Insurance

- The KMA opposes imposition of mandated health insurance benefits. Selection of health insurance benefits should be based on individual or group needs in conjunction with medical requirements or economic limitations of the insured.
- Medicare supplement policies should adhere to Federal guidelines, terms and conditions as imposed upon the primary Medicare policy. Definitions of emergency or other conditions should parallel Medicare definitions.
- Managed care is designed to reduce costs and maintain quality of medical care. A system should be developed to monitor managed care and assure patients' decreased costs, along with quality of medical care.
- Health insurance companies should be required to better inform policyholders of limitations, exclusions and specific requirements which plans may contain.

Vehicular Safety

The KMA supports the adoption of several laws to save lives and reduce medical costs:

- Stringent bus safety and inspection programs to assure high levels of safety for school children and other passengers.
- Allowable blood alcohol content (BAC) of Kentucky drivers should be reduced from 0.10 to 0.05.
- Children under 12 years of age should not operate ATVs; helmets should be required for all ATV operators and passengers; ATVs should not be permitted on public highways, streets, etc; horsepower limits should be placed on ATVs operated by children ages 12-16.
- All passengers in moving vehicles should be required to use safety belts.
- Periodic testing of vision should be required at the time of driver's license renewal.
- Minors should not be permitted to ride in the rear of open trucks.
- Mandatory motorcycle helmet law should be retained.
- Addition of lap-shoulder systems as standard equipment in rear outboard seating positions.

Retirement Plan

The KMA supports protection of retirement plans from judgment. Protected retirement plans shall be "qualified" ERISA retirement plans as defined by the Internal Revenue Code. The retirement plans will not be protected from awards per a divorce decree or child support orders.

Indigent Care

The KMA recognizes that approximately 220,000 Kentuckians are uninsured and considered indigent. The Association proposes a plan based on Medicaid using the KenPAC approach, which offers basic medical services. Funding for the program could be obtained by taxes from various sources available to the Legislature. The KMA supports additional funding for prenatal and pediatric care and recommends that portions of the Kentucky lottery money should be used for this purpose.

Nonphysician Practitioners

The explosion in the number of nonphysician personnel has added to the spiraling costs of medical care. The KMA opposes licensure of health care workers. Additional certification of health care personnel should be considered on a case-by-case basis. Diagnosing, prescribing and independent practice and billing by health care workers shall be opposed by the KMA. Enhancement of practice acts by nonphysician practitioners, through legislative fiat rather

than through education, is inappropriate. Mandated health insurance coverage for services provided by nonphysician practitioners should be opposed.

Alcohol

The KMA supports legislation to require, in all places where alcohol is sold, the posting of warning signs that drinking alcoholic beverages during pregnancy can cause birth defects.

Health Education

The KMA recommends that health education be taught to all students from kindergarten to 12th grade.

Living Will

The KMA supports the living will concept and the adoption of such legislation in Kentucky.

Animal Research/Facility Protection

The KMA acknowledges its commitment to the humane treatment of animals used in biomedical research. KMA supports the establishment of minimum criminal penalties for the unauthorized removal of research animals or willful damage to the research animals or willful damage to the research facility or project.



KMA POLICY DURING
KENTUCKY GENERAL ASSEMBLY



KMA HOUSE OF DELEGATES

POLICY ON LEGISLATIVE ACTIVITIES

THE KMA House of Delegates has approved the following policy regarding the coordination of state legislative activities:

1. All state legislative proposals are to be coordinated by and channeled through the Committee on State Legislative Activities
2. The composition, authority, and function of the Quick Action Committee are to be retained
3. The composition, priority, manner, and time of introduction of state legislative proposals are to be left to the discretion of the Chairman of the Committee on State Legislative Activities and the Quick Action Committee

It should be pointed out that while KMA staff is in Frankfort for the Kentucky General Assembly, they are responsible only to their immediate superiors and not to individual members of the Association. Any complaint relative to the state legislative program or its operation should be directed to the State Legislative Committee Chairman and not to staff. KMA's staff and legislative representatives have been instructed not to carry out any recommendations or suggestions presented to them by anyone without first seeking the approval of the Committee on State Legislative Activities or its proper representatives.



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**Wally O. Montgomery, MD, Chairman,
KMA Committee on State Legislative
Activities.**

*"Every person owes part of his time
and money to the business or industry
in which he is engaged. No person has
a moral right to withhold support from
an organization that is striving to
improve conditions within his sphere."*

— TEDDY ROOSEVELT

KMA COMMITTEE ON PROFESSIONAL LIABILITY INSURANCE

1991-1992 Associational Year



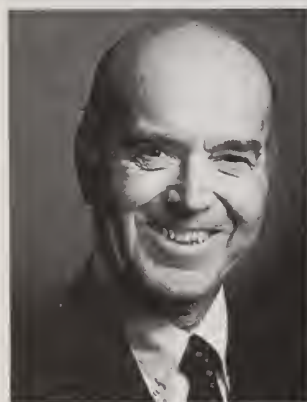
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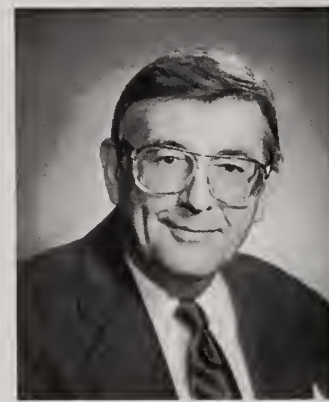
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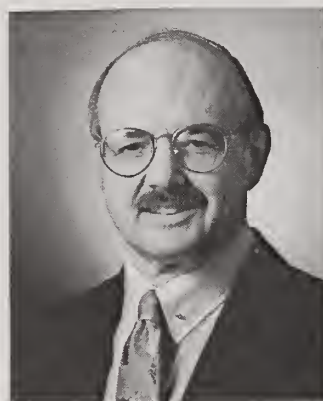
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. . . but in every legislative session, they vote on nearly 150 bills that determine the kind of care you can provide to your patients!

Medicine's views on these important issues are critical to ensuring that good legislation becomes law — and that bad legislation doesn't. KEMPAC helps make sure our views are heard!

KEMPAC supports legislative candidates whose voting records and personal philosophies indicate a willingness to listen to and consider medicine's views. By supporting KEMPAC, you'll be helping to see that members of the Kentucky General Assembly continue to receive the best medical advice on legislation which affects our patients and our profession!

Good legislation is in the eye of the beholder — CARL COOPER, JR, MD, KMA PRESIDENT 1978-1979

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1992 KMA

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LEGISLATIVE REPORT



EPHRAIM MCDOWELL
OF
DANVILLE, KENTUCKY
PIONEER SURGEON
FATHER OF "VARICO" OMT
BORN NOVEMBER 11, 1795
DIED JUNE 20, 1850

RHODE ISLAND MEDICAL JOURNAL
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COVER — Pioneer physician Ephraim McDowell stands in the rotunda of the state capitol amid some of Kentucky's most prestigious sons. President Abraham Lincoln stands in the center, surrounded by McDowell (monument in the background); Senator Henry Clay, Kentucky's most famous statesman; Jefferson Davis, President of the Confederacy during the Civil War; and Alben Barkley, US Vice President.

FOREWORD

We are pleased to present the Report of the 1992 Kentucky General Assembly. A narrative description of the session by Wally O. Montgomery, MD, Chairman of the Committee on State Legislative Activities, is included along with a brief summary of each legislative proposal relating to medical care. The various bills are categorized for future reference and easy reading.

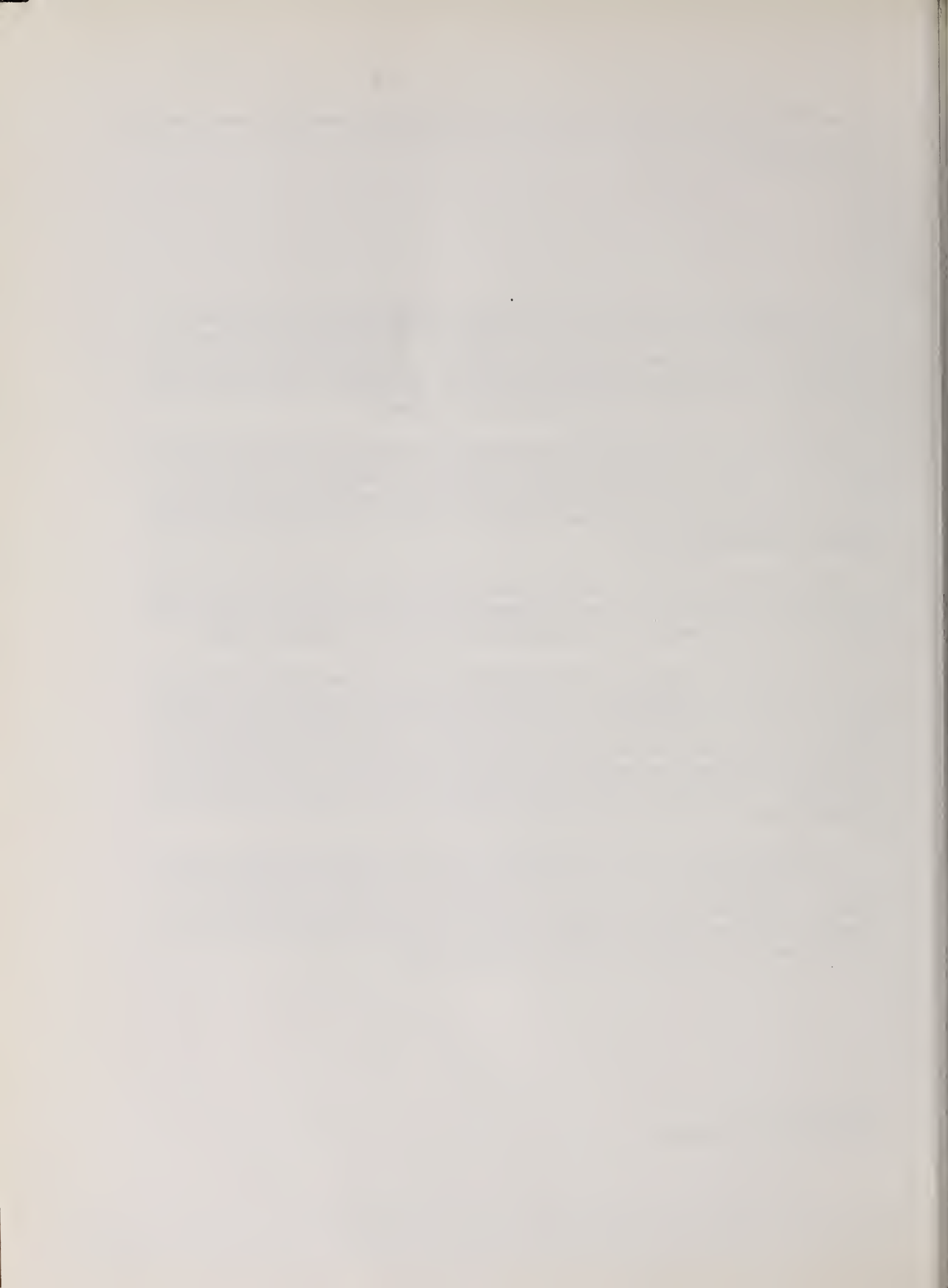
We thank members of the General Assembly for their service to the citizens of Kentucky and for consideration of KMA's positions on legislation. As you review the various bills that were introduced, particularly those that would have had an adverse impact upon the practice of medicine, I believe you will agree that KMA had an outstanding session.

Special tribute goes to the KMA Legislative Quick Action Committee and staff for their contributions. We were extremely impressed with the interest and participation by members of the Association before and during the session.

The Governor's call for a special session of the General Assembly in November for the purpose of addressing access and affordability of health care presents special concerns. The KMA Board of Trustees has developed an extensive plan for reform of Kentucky's health care system. As the special session unfolds, KMA leadership will need your confidence and personal support. In my 30 years of association with KMA, there has never been a time when a greater need existed for physicians to join forces and speak as one voice.

Take time to review the 1992 session results and become familiar with the issues. This background material will equip you with necessary information to discuss the issues with members of the General Assembly during the special session. If we can provide additional information or respond to your questions, please feel free to contact us at KMA headquarters.

Robert G. Cox
Executive Vice President



COMMITTEE ON STATE LEGISLATIVE ACTIVITIES

KENTUCKY MEDICAL ASSOCIATION

**REPORT OF THE 1992
KENTUCKY GENERAL ASSEMBLY**

WALLY O. MONTGOMERY, MD, CHAIRMAN



REPORT FROM THE CHAIRMAN

The 1992 Kentucky General Assembly wrapped up the session on April 15, 1992. 1,923 bills and resolutions were introduced and KMA followed 193 of these bills.

We normally expect various professional organizations or public advocacy groups to introduce legislation mandating that specific services or illnesses be covered under health insurance contracts. This is the primary reason why many small businesses, who are excluded from the ERISA self-insurance provisions, choose not to insure their employees. Podiatrists and psychologists sought mandates for their services and two other bills mandated payment for PKU formulas and fertility services. We received objections from several physicians relating to our opposition to the fertility mandate but based on KMA House of Delegates position, we objected to the measures. All four mandates failed. In a period when society struggles to find a way to provide basic health insurance for 15-20% of our population, additional mandates are untimely and inappropriate.

The usual plethora of nonphysician practitioner bills to expand practices or mandate payment for services were introduced. We successfully opposed all these proposals except for SB 251 which, after three attempts, authorized optometrists a seat on boards of health. However, three seats on every board of health remain dedicated to physicians.

While tort reform continues at the top of our agenda, unfortunately we spent most of the time on the defensive in 1992. HB 322 required quite a lobbying effort. It would have expanded the loss of consortium statute from what is now defined as husband and wife relationships, i.e., sex, to include parent and child relationships. We wrestled with this bill throughout the session and finally amended out provisions relating to parents and children. Another unsuccessful proposal would have extended the statute of limitations in malpractice cases from one year to 18 months. There were several wide-ranging proposals relating to wrongful death statutes. Bills to increase civil penalties and a unique proposal relating to pre-judgment interest court costs would have increased the cost of malpractice insurance. For the fourth successive session, KMA introduced the constitutional amendment to section 54 that would allow the General Assembly to cap non-economic awards. We will continue to press for this amendment. However, if we are to succeed, we must garner business and public support.

We were fairly successful in the area of health and safety in that we saw passage of HB 352 which restricts childrens' access to tobacco. That bill, based on House of Delegates directives, increases the age at which children may purchase tobacco, establishes fines, and restricts billboards near schools. The General Assembly adopted HB 750, also a House of Delegates directive, which requires children to successfully complete the 8th grade before competing in varsity football, wrestling, and soccer. We supported legislation relating to maternal/fetal conflict, which included a require-

ment that signs be posted in liquor retail establishments warning of the use of alcohol during pregnancy. This also was a House of Delegates directive. The Senate was so impressed with the need for these signs that they mandated that a similar sign be posted in every Kentucky physician's waiting room. On the down side, we were extremely disappointed that the mandatory seat belt law failed. We believe this bill will be adopted in the next session. We also lobbied proposals to prohibit children from riding in open vehicles and legislation relating to boat and water safety.

We see an increasing interest in patient access to medical records. There were considerable child abuse bills, with practically all the bills seeking access to medical records; not necessarily by the child, parent, or attorney, but by various advocacy groups. Another bill, which was not adopted, dealt with transfer of records, and mirrored AMA's and Board of Medical Licensure's policy.

Because several emergencies occurred due to the inability of pharmacists to decipher MDs' names which were unreadable and written on generic prescription pads, physicians will now be required to list their name, address, and phone number on every prescription. This will require some adjustment, but under the circumstances it was impossible to oppose.

Mandatory CME reared its head again, but we were able to defeat it one more time. It is becoming increasingly impossible to explain to legislators our opposition to mandatory CME. Physicians are now the only licensed profession in Kentucky without some statutory requirement for continuing education. Other measures included legislation establishing a statewide health information system to collect, analyze, and disseminate charges, payment, and quality data. This proposal failed but will return during the special session. A bill passed requiring a birth defects registry while legislation mandating CON for physicians' offices which perform abortions failed. We successfully opposed a proposal that would have prevented balance billing for state employees.

Government programs, including Medicaid and Workers' Compensation generated a great deal of KMA activity during the session. We spent considerable effort working with these programs. We also had to deal with several rumors indicating that the Governor would recommend reductions in physician reimbursement, similar to that extracted from hospitals.

In the final days of the session, a Senate proposal to delete guarantees provided to physicians under HB 21 which taxes Medicaid reimbursement, was withdrawn. Proposed Workers' Compensation omnibus revisions would have mandated deposition fee schedules, required written notice of self-referrals, and included provisions that may have delayed payment. We wrestled with this bill throughout the session. The bill was tabled on the final day of the regular session.

There were a number of living will bills which attempted to bring Kentucky statutes in line with the Cruzan case. Several abortion bills which were extremely controversial and highly publicized, died despite several bitter committee and floor fights to extract them from the Senate Judiciary committee.

There were twelve bills introduced during the session which were "precursors to health reform." All of these proposals were innovative and called for dramatic alterations in our present delivery system. I strongly urge each of you to read this particular section and become acquainted with the concepts presented. They will surely return during the special session.

The special session creates tremendous concerns for KMA, not just from a legislative perspective, but peripheral concerns that threaten to alter the playing field. Of major concern is the effect the federal grand jury's investigation will have on legislators, lobbyists, and business. The possibility exists that we could be dealing with new legislative leadership. Many observers are skeptical as to how long the Administration and the General Assembly's honeymoon will last. We have already observed open clashes between legislative leadership and the Governor over government ethics and relationships between legislators and lobbyists. The legislature demands that the Administration operate under the same rules to which it is expected to adhere.

We will see a barrage of negative reporting from the media directed toward health care providers and costs in general. Numerous public advocacy groups will press for universal health insurance for all Kentuckians and limitations on provider charges. Physician participation on the local level may determine the final outcome.

In conclusion, I want to take this opportunity to thank you for the work, the support, and the contact you generated with legislators. You did a good job this year by writing letters and contacting legislators. Thanks to the Board of Trustees for its trust and support and special accolades to members of the Quick Action Committee who journeyed to Frankfort every Wednesday evening for a four to five hour session reviewing legislation and providing direction to our lobbyists. We are grateful to the entire KMA staff for their work during the General Assembly. A team effort requires that all members of the staff get involved, whether its lobbying in Frankfort or taking care of business back home.

Wally O. Montgomery, MD, Chairman
Committee on State Legislative Activities

This handbook contains brief summaries of legislation relating to health care and medical practice. If the reader has interest in a particular bill, a full copy may be obtained by contacting the Legislative Research Commission at 502-564-8100.

The Kentucky General Assembly adjourned on April 15, 1992. During the Session 1,923 bills and resolutions were introduced. The breakdown of **adopted** bills is as follows:

Senate Bills (SB)	151
Senate Concurrent Resolutions (SCR)	5
Senate Joint Resolutions (SJR)	8
Senate Simple Resolutions (SR)	<u>182</u>
TOTAL	346
House Bills (HB)	276
House Concurrent Resolutions (HCR)	12
House Joint Resolutions (HJR)	12
House Simple Resolutions (HR)	<u>250</u>
TOTAL	550
TOTAL BILLS BOTH CHAMBERS 896	

One bill, HJR 87, became law without the Governor's signature. The Governor vetoed 4 bills and the General Assembly subsequently overrode 2 of the vetoes, thus sustaining vetoes on 2 bills.

Of the 896 proposals enacted, 432 were simple resolutions which are adopted only in the originating chamber by voice vote. In terms of regular Senate and House bills, 1,378 were introduced with only 427 enacted.

The following Legend will assist you as you review this book:

LEGEND

Bold Type	Legislation adopted by the General Assembly.
*Asterisk	Refers to KMA House of Delegates Reports and Resolutions
COSLA	Committee on State Legislative Activities
SB Senate Bill	HB House Bill
SCR Senate Concurrent Resolution	HCR House Concurrent Resolution
SJR Senate Joint Resolution	HJR House Joint Resolution
SR Senate Simple Resolution	HR House Simple Resolution

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AIDS/COMMUNICABLE DISEASES

- HB 193** Required conscious/competent persons with STDs or other communicable diseases to notify EMS personnel and health care providers of their disease. The bill also required health care providers to notify EMS personnel if the latter have been involved with a patient so infected. The provider must give EMS workers the name of the patient and identify the disease in question. Health care facilities are required to notify EMS personnel if they are going to transfer a patient with a communicable or sexually transmitted disease; the bill stated that failure to give such notice shall constitute a Class "D" felony. The bill contained a prohibition against EMS or health care providers divulging information regarding infected persons to anyone who does not have a statutorily defined need to know. Improper disclosure constituted a Class "A" misdemeanor for first offenses; a Class "D" felony for second and subsequent offenses. KMA avoided an additional amendment mandating that all MDs publicly disclose their HIV status. *Opposed*
- HB 835** Changed the statute of limitations for work-related AIDS claims from 2 to 10 years. *Monitored*
- SB 170** Communicable disease control bill. *Supported*
- SB 244** **Creates felony convictions for HIV-infected persons who offer or agree to engage in prostitution.** *Supported.* **ADOPTED**

ABORTION

- HB 180** Required the consent of at least one parent or guardian before birth control devices could be prescribed for unmarried minors. *Opposed*
- HB 203** Defined "abortion facilities" as any place in which an abortion is performed. The bill specifically excluded "abortion facilities" from the requirements of CON. However, it also altered the physician office exemption to include MD offices which are also "abortion facilities" under the regulatory and licensure umbrella of CHR. The bill required CHR to establish licensure standards and procedures for "abortion facilities." The measure set up deadlines for promulgating the regulations and for "abortion facility" operators to get licenses for their facilities. The bill also established requirements for linkage agreements between "abortion facilities" and acute care hospitals in order to deal with unforeseen complications. The linkage agreements included provisions for ambulance services. *Monitored*
- HB 479** Abortion proposal - companion bill to SB 115. *Monitored*

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- HB 565** Redefined the term "abortion." It also imposed new requirements regarding patient information, the time frame within which such information must be provided, and established a mechanism for awarding punitive and treble damages where abortions are attempted without complying with the requirements of the Act. *Monitored*
- SB 115** Changed the Kentucky abortion law struck down by the federal courts. The amended version required that a minor and one parent or legal guardian, instead of the minor and both parents or legal guardian, consent to the performance of an abortion. The bill also removed the requirement that the minor's informed written consent to the abortion be signed and notarized. *Monitored*

ALCOHOL/DRUG ABUSE

- HB 192** **Maternal/fetal conflict.** Calls for education of health workers and establishment of various demonstration projects. Creates a substance abuse and pregnancy work group. Permits physicians to screen pregnant women for alcohol and substance dependency. Requires licensed retail vendors of alcoholic beverages and physicians' offices to post warning signs that alcohol use by pregnant women is dangerous. A KMA amendment to delete mandatory CME was adopted. **Supported per 1988 Resolution N*
ADOPTED
- HB 751** Provided that a parent is guilty of endangering the welfare of a minor when that parent unlawfully uses controlled substances during the child's fetal period and where, as a result of such use, the child suffers serious physical injury, mental retardation, mental illness, or other forms of permanent damage. Such an offense was designated a Class D felony. *Opposed*
- SB 276** Created numerous new provisions and set standards for various juvenile and adult drug abuse and alcohol treatment programs. *Monitored*
- SB 396** Prohibited state employment or licensing of anyone ever convicted of a drug offense as defined in the bill. The legislation also increased the penalties for drug offenses and revised the elements of various controlled substance offenses. *Opposed*

BLOOD DONATIONS

- HB 117** **Allows 17 year-olds to donate blood to a "voluntary" program without parental consent.** Requires that the program make reasonable efforts to give parents advance notice of its intent to solicit blood donations. *Monitored.* **ADOPTED**

CERTIFICATE OF NEED

- HB 275** Related to "retirement communities" and exempted such entities from the requirements of CON. The bill established certain prerequisites for qualification as a retirement community and allowed personal care beds to be brought on line without a CON. *Monitored*
- HB 476** Exempted "non-emergency health transportation" from the requirement of CON. *Monitored*
- HB 672** Required General Assembly approval of gubernatorial appointees to the CHECK. It authorized the Interim Joint Committee on Health and Welfare to review such nominations when the KGA is not in session. The Governor selected a chairman from the members confirmed by the KGA and was given the power to remove members for neglect of duty, etc. *Monitored*
- SB 236** Added "sleep disorder clinics" to the CON coverage umbrella and specifically exempted a list of services and equipment from the definition of "health services," thereby eliminating them from CON coverage. *Monitored*
- SB 243** Created a new exemption from certificate of need. The bill would allow a "nursing facility" as defined in public Law 100-203 to convert independent living units or apartments to nursing facility beds without first obtaining a CON. In order to qualify for this exemption at least 12, but no more than 25 beds, could be converted, and no more than 1/3 of the converted beds may be certified for participation in the Medicaid program. Such a conversion must be completed by December 31, 1992. *Monitored*
- SB 283** Codified the provisions of the State Health Plan. It also abolished the CHECK and transferred that commission's authority to CHR. More importantly, the legislation would have established a two year blanket moratorium on the establishment or construction of any new health facility or service. The stated purpose of this legislation was to stop expansion in the health care arena until the Blue Ribbon Task Force and the KGA Special Session addressed this issue. *Monitored*
- SB 416** Exempted personal care homes and nursing facilities from Certificate of Need. *Monitored*

CHILD ABUSE/SEX OFFENSES

- HB 292** Established new criminal penalties for child abuse. Should the child be under the age of 12, the offense is a Class "A" felony. *Monitored*

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- HB 301 Amended the Unified Juvenile Code; authorized local citizen review boards to have access to specified records of abused and neglected children. The bill established the scope of review for such boards and required them to report their findings and recommendations to CHR and the appropriate Court. *Opposed*
- HB 368 Addressed access to child abuse records, expanded the requirements of confidentiality regarding child abuse records, and required that such records be destroyed if the report of abuse or neglect was unfounded. Also included the investigative reports generated by administrative agencies in the list of records to be disclosed only by court order. *Monitored*
- HB 481 **Proposes HIV testing of individuals convicted of certain sex offenses; requires that a person convicted of such crimes be tested for HIV at the request of the victim or the parent or guardian of the victim. Test results will have a limited distribution, going only to the victim, the victim's parent or guardian, CHR, or the victim's attending physician. Amendments require that results of HIV testing be made available to the court ordering the test and that CHR provide counseling to victims and juvenile offenders. *Supported. ADOPTED***
- HB 631 **Addresses DNA testing of persons convicted of sex offenses, the creation of a DNA data-bank, and the use of such information regarding future sex crimes. The bill requires that offenders pay for the test and creates a Class D felony for tampering with a sample. *Supported. ADOPTED***
- HB 637 **Relates to affidavits of paternity, filing with the state registrar and various other matters pertaining to birth certificates and social security numbers of children born out of wedlock. ADOPTED**
- HB 825 Addressed child sexual abuse and required that an interdisciplinary team be established to investigate sexual abuse charges; those involved in dealing with child sexual abuse must be properly trained and that certain described services be made available to the victims of abuse and those participating as witnesses. *Monitored*
- HB 881 **Establishes a multidisciplinary team for dealing with child sexual abuse investigation; various training requirements for those dealing with abuse cases; establishes services for victims and witnesses and calls for registration of those convicted of sex offenses involving children. *Supported. ADOPTED***

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- HB 896** Addressed standards for placing children through independent adoptions. KMA questioned confidentiality of records. *Opposed*
- HB 930** Outlined family care leave and employment practices involving leave for pregnancy, child birth, or related medical conditions. The bill dealt with certification by a health care provider of the existence of a serious health condition and required that the physician make certain representations about the probable duration of the condition, the amount of time needed to care for the person suffering from that condition, and that such condition warranted participation of a family member to provide such care, etc. *Monitored*

CORPORAL PUNISHMENT

- HB 68** Permitted local boards of education to adopt policies permitting corporal punishment within their district. The boards must establish conditions and circumstances under which corporal punishment may be applied and they must be filed with the state board of elementary and secondary education. The state board may disapprove the policy "for cause." **Opposed per Report of Committee on School Health, Physical Education, and Medical Aspects of Sports 1991 House of Delegates*
- HB 70** Prohibited the state board of elementary and secondary education from enacting regulations prohibiting the use of corporal punishment. **Opposed per Report of Committee on School Health- 1991 House of Delegates*
- HB 715** Deleted the prohibition against CHR promulgating regulations which limited the use of reasonable corporal punishment or discipline in church-related privately operated child-caring agencies or facilities. *Monitored*
- SB 201** Prohibited the use of corporal punishment in schools. **Supported per Report of Committee on School Health - 1991 House of Delegates*

HANDICAPPED

- HB 447** Calls for the creation of supported living councils in counties throughout the state. These groups would work through CHR to develop a plan of supportive services for developmentally disabled individuals. *Monitored. ADOPTED*
- HB 587** Required that those who are deaf or hard of hearing be offered interpreter services when they are receiving Medicaid benefits. *Monitored*

HB 740 Requires CHR to provide accommodations and services for deaf or hard of hearing individuals so they can have access to various mental health services. Such accommodations would include interpreter services, mental health assessments, and education and training for staff personnel who coordinate services for the deaf or hard of hearing. The bill also establishes a 16-member advisory council and requires periodic reporting to the Secretary for CHR, the Interim Health and Welfare Committee and others. *Monitored.* **ADOPTED**

SB 96 Requires that all agencies of State Government promulgate administrative regulations providing accessibility to all services by those who are deaf or hard of hearing in compliance with federal mandates. *Monitored.* **ADOPTED**

HEALTH CARE REFORM

HB 90 Proposed "pooling" employees of small businesses in order to obtain better health insurance rates. *Monitored*

HB 150 Established "The Kentucky Small Business Health Access Corporation" to organize employers of 24 or fewer to obtain group health insurance. Imposed \$1 service charge on a hospital or outpatient admission. *Monitored*

HB 240 Eliminated "discounting" in health care purchasing. *Monitored*

HB 272 Established a statewide health information system to collect, analyze, and disseminate health care charges, payments, and quality data. *Monitored*

HB 338 Established two dedicated "funds" from proceeds of the Kentucky Lottery. The first received 5% of the net proceeds of the Lottery and was called the "Local Lottery Share Fund." These monies would be used to "improve the safety and quality of life" for local area residents. The legislation established a formula pursuant to which these monies were to be distributed to the various local governments. The second fund, the "Medically-needy Lottery Share Fund" would have received 45% of the net proceeds of the lottery. These funds would be channeled to CHR and used to increase the income eligibility guidelines for Medicaid and AFDC to the maximum level allowable under federal law. *Monitored*

HB 430 Called for the creation of a Small Employer Insurer Committee which would recommend to the Commissioner of Insurance certain health care plans for use by employers having not less than three nor more than 25 employees. *Monitored*

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- HB 490** The Republican Caucus proposal for health insurance reform. It established the Kentucky Health Insurance Corporation with tax credits to employers who purchase group health insurance; specified basic benefits; limited reimbursement to Medicare rate or Medicaid in some instances; required patients to waive right to file malpractice claims and submit to arbitration panel; provided reductions in malpractice premiums for providers who participate in the program. *Monitored*
- HB 804** Required development districts to establish a basic hospitalization program to cover employers of 25 or fewer employees. Established basic benefits and coverage; exempted such programs from "mandated" services; prohibited pre-existing conditions provisions from excluding or limiting coverage beyond 12 months. *Monitored*
- HB 898** Created the Kentucky Universal Health Insurance Plan (KUHIP). Legislation provided universal health insurance coverage to all Kentucky residents. It established a Board of Governors, their term in office and duties. The measure set forth the services covered under KUHIP and established ground rules under which a provider and a plan member became "participants." *Monitored*
- HB 927** Created a Health Care Reform Board; provided a single publicly-financed program of basic health care coverage for residents below established poverty levels (200%) who are unemployed. Basic Health Care Trust Fund was created to include Medicaid, Medicare, and all public and private health insurers. Required all residents to maintain health insurance, prohibited physician referral to services, etc. in which physician or family has a vested interest and prohibited labs, etc. from accepting such referrals. Regionalized high-tech, high cost hospital services under CON and prohibited insurers from reimbursing anyone other than "centers of excellence" for these services. Employers required to provide health insurance for all employees and pay 80% of cost; community rating required; primary care physicians must be referral service for all specialists except in emergencies; reimbursement rates 110% of Medicare unless otherwise negotiated. *Monitored*
- SB 249** Health Care Reform Act established (1) the Kentucky Primary Care Plan designed to provide coverage for limited physician services, outpatient hospital services, prescription drugs, and laboratory services; eligible persons included those whose incomes did not exceed 200% of the federal poverty guidelines; cost per participant - \$20 per individual and \$30 per family; all health care providers required to participate in the program. The program required co-payments for physician services and hospital outpatient services. The CHR would develop the program and promulgate regulations to implement the proposal. The rate of reimbursement

for hospital services reflected the costs incurred for providing services to persons with incomes up to 100% of the federal poverty level. (2) Family practice physicians practicing in geographic areas with no more than two primary care physicians per 1,000 population would be reimbursed 150% of the standard reimbursement rate for physicians' services. (3) Infants born to Medicaid recipients would be presumed to be eligible for Medicaid reimbursement at birth. (4) A schedule of the maximum allowable prices that may be charged by hospitals to patients would be limited to the Medicare level. This applied across the board for all third party payors and/or paying patients. (5) A physician licensed in Kentucky would accept as payment in full the fees for services approved by Medicare for all Medicare beneficiaries. No physician would collect more than the Medicare approved amount for Medicare beneficiaries. (6) By January 1, 1993, all health insurance companies would be required to reduce premiums by a maximum of 20% and use community rating methods which would only differentiate between single persons, two persons, two-parent families, and a single-parent family. Under the rating system, age, sex, health status, occupation, location, or any other factor of the covered person would not be taken into account in setting the rate. (7) A final section of the bill was designed to provide access to health insurance for those denied insurance or considered uninsurable. A special plan would be established to determine reimbursement rates and coverage. *Monitored*

- SB 317** Health Care Reform Bill, created the Kentucky Health Corporation. Called for a single payor for third-party health care service payments and a board of directors to oversee the corporation and determine reimbursement levels. It required a Medicaid waiver and mandated that all providers accept KHC established rates as payment in full except for co-payments or deductibles. All health insurance contracts, including HMOs required to cover minimum services and use a community rating system to establish rates. *Monitored*

HOSPITALS

- HB 310** Establishes the category of Rural Primary Care Hospitals. Permits hospitals to convert to a RPCH without a CON; sets forth staffing requirements and services to be provided. KMA was successful in efforts to delete sections permitting ARNPs and PAs to admit and prescribe. The bill contains an emergency clause. *Monitored with amendment. ADOPTED*

HB 372 Establishes a birth defects registry, the stated purpose of which is to provide information on the incidence, possible causes, and preventive strategies for reducing the incidence of birth defects, still-births and miscarriages. This bill calls for the registry to be operated by the Department for Health Services. The department may require acute care hospitals to maintain a list of patients who have been discharged with a diagnosis of still-birth. The same requirement exists for patients diagnosed as having a birth defect; the definition of birth defect is to be established by the department upon the recommendation of an appointed advisory committee. The bill grants the department authority to require that both acute care hospitals and free standing birthing centers make medical records available to department staff where patients have been diagnosed as having a birth defect or discharged with a diagnosis of still-birth. The legislation requires the department to appoint an advisory committee to assist in implementation of the act, address the need for confidentiality, grant the department authority to publish statistical compilations relating to birth defects. Such compilations must not in any way identify individual cases. *Supported. ADOPTED*

HB 440 Required all acute care hospitals to provide CHR with a list of charges for specified services and certain quality indicators for a category of services to be delineated in CHR regulations. This same material must be distributed to each hospital patient without charge. Such reports were to be made available to the public and failure to comply could result in fines ranging from \$100 to \$10,000. *Opposed*

SB 97 Acuity based staffing plan for hospitals. All hospitals must provide, as a condition of licensure, an acuity based staffing plan in accord with staff/patient ratios established by this legislation; nursing supervisors and administrative personnel cannot be counted in establishing the ratio; would prohibit nurse work weeks in excess of 40 hours without consent; the bill also outlined when a nurse may refuse a patient assignment. *Opposed*

INSURANCE

HB 92 Repealed the provision requiring college students to have minimum health insurance coverage. *Opposed*

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- HB 97** Established situations in which Kentucky law would control issues arising under health insurance policies; provided that Kentucky law shall govern whenever group health insurance covers a resident of Kentucky who files a claim arising from an accident or illness occurring in Kentucky, even if the policy was delivered or issued for delivery outside the Commonwealth. *Monitored*
- HB 112** Amended the no-fault automobile insurance law to allow for insurer to offer the option of having basic reparation benefits provided in a "managed care" setting. The bill established certain other requirements and mandated that the insurer must demonstrate in rate filings that the insured will realize savings under such a plan. Amendment required that the "emergency physician" or attending physician determine when a patient is stabilized and the transfer is in accord with federal and state laws. *Monitored with amendment*
- HB 151** Required that all authorized insurers and health maintenance organizations offer all their coverage statewide. An insurer or HMO would not be allowed to deny enrollment based upon an individual's place of residence. *Monitored*
- HB 152** Required that health insurers and health maintenance organizations provide the same benefits at the same cost for all state employees. *Monitored*
- HB 282** Required health insurers to offer basic health benefit coverage, free of statutory mandates, to those desiring such benefits. The bill established certain conditions and requirements which must be built into the basic coverage plan. *Monitored*
- HB 283** Required that HMOs notify enrollees of the financial incentives given to those who provide care in these settings. The bill also required that all health care providers, not just hospitals, provide patients with an "understandable itemized statement" prior to the time a bill is submitted for payment. *Opposed*
- HB 295** **Permits public employees or those retired from public employment to change health insurance carriers without limitation for pre-existing conditions. Corresponding provisions are in the bill for the state administered retirement plan and the county employees self-funded retirement plan. *Supported. ADOPTED***

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- HB 347** Defined infertility; required all insurers and other entities involved in providing health coverage to pay medically necessary expenses incurred in diagnosing and treating infertility. **Opposed per long-standing House of Delegates position on mandated benefits.*
- HB 452** Required that carriers reduce individual health insurance rates to 10% below those charged on December 1, 1991. The bill also required the Insurance Commissioner to hold a hearing on health insurance rate increases. *Monitored*
- HB 566** Prohibited balance billing of state employees for services covered under their health care insurance contracts. The bill stated that a provider who willfully violates the balance billing prohibition is guilty of a Class B misdemeanor. *Opposed*
- HB 635** Called for health insurance to provide a discount to policy holders who are non-smokers. *Supported*
- HB 678** Established minimum standards and requirements for Medicare supplement insurance policies. The bill would prohibit duplication of benefits already provided by Medicare; the exclusion of benefits for losses incurred more than six months after the effective date of the policy where the loss resulted from a pre-existing condition; and, authorized the Insurance Commissioner to promulgate regulations establishing standards for such policies. *Monitored*
- SB 146** Mandated coverage under health insurance policies for services provided by psychologists and social workers. **Opposed per long-standing House of Delegates position on mandated benefits.*
- SB 157** Mandated coverage under health insurance policies for services provided by podiatrists. **Opposed per long-standing House of Delegates position on mandated benefits.*
- SB 195** Mandated coverage under health insurance policies for special medical formulas prescribed as medically necessary for the treatment of PKU. **Opposed per long-standing House of Delegates position on mandated benefits.*
- SB 217** Addresses long-term care insurance policy and disclosure standards, cancellation requirements and limitations on marketing practices, etc. *Supported. ADOPTED*

LIVING WILL

- HB 456** Revised the living will and health care surrogate acts. Intended to update these laws in light of the "Cruzan decision;" contained provisions sought by the KAHCF to assist in dealing with incompetent patients who had not executed an advance directive. Controversy surfaced concerning provisions dealing with artificial nutrition and hydration. ****Supported per COSLA Report - 1989 House of Delegates***
- HB 629** Proposed to revise the living will and health care surrogate acts. A much simpler approach to advance directives; established a hierarchy of decision makers where patients had neither executed an advance directive nor named a health care surrogate. ***Monitored***
- SB 430** Revision to the living will/health care surrogate acts. ***Monitored***

MEDICAID

- HB 160** Expanded Medicaid services to include prevention and treatment of STDs and HIV for requesting minors and adults; education regarding birth control drugs and devices for requesting minors and adults; non-therapeutic sterilization for requesting adults; alcohol and substance abuse prevention and treatment for pregnant women; and alcohol and substance abuse prevention and treatment for minors. ****Opposed per long-standing House of Delegates position that basic services should be fully funded before adding new services.***
- HB 308** Required that Medicaid "fully participate in the Title XIX Optional Coverage Provision for presumptive eligibility for pregnant women and children." Required that CHR process applications filed by low income pregnant women who desire to participate in Medicaid. Participation would be provided at the delivery sites most frequently used for prenatal care by low income women as determined from a review of Medicaid payments to providers of prenatal care. Required CHR to promulgate regulations governing the weekend and evening operation of all local/district health departments providing prenatal care. Provision calling for the establishment of five Resource Mothers Projects for pregnant and parenting teenagers. The most troubling provision in the bill dealt with nurse midwives. It stated that ". . . no hospital shall prohibit an ARNP designated by the Board of Nursing as a nurse midwife . . . from utilizing the hospital for childbirth and delivery services, solely on the basis of being a nurse midwife." ****Opposed per long-standing House of Delegates position that basic services should be fully funded before adding new services.***

MEDICAL PRACTICE

- HB 95** Prohibited the sale of human organs. *Opposed*
- HB 158** Established procedures for transferring the medical records of active patients when a physician dies or otherwise leaves his practice. The provisions of this bill were nearly identical to sections contained in the Current Opinions of AMA's Council on Ethical and Judicial Affairs. **Opposed per House of Delegates opposition on practice management restrictions.*
- HB 588** Prohibits any activity relative to the distribution or sale of "transplantable" organs where the fee charged exceeds the direct and indirect costs of procuring, preserving, distributing, and transplanting the organ. "Transplantable organ" is defined and criminal and civil money penalties are prescribed for those who violate the bill's prohibition. *Supported. ADOPTED*

MENTAL HEALTH

- HB 116** Children with emotional disabilities. **ADOPTED**
- HB 121** Added a mental health exam to the list of care items to be provided children under court ordered temporary custody. *Monitored*
- HB 554** Set up a new CON and licensure category for "psychiatric residential treatment facilities." The bill spoke in terms of "community based" and "home-like" facilities which were to be certified by JCAHO and which must meet certain other requirements. *Opposed. ADOPTED*
- HB 661** Prohibited placing charges against a mentally ill person solely or primarily for the purpose of placing that individual in jail rather than in a mental health facility. *Monitored*
- HB 709** Expanded the category of individuals eligible for specialized sex offender treatment programs to those who are mentally retarded. The bill called for an individualized treatment program designed to appropriately accommodate the offender's mental functioning level. *Monitored*
- HB 854** Changed a number of definitions, including that of "least restrictive alternative mode of treatment." Also modified existing law concerning commitment proceedings. *Monitored*

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- HB 947 Required prior parental consent for any psychiatric or psychological testing or treatment in public schools. The definition of "psychiatric or psychological examination or test" was extremely broad as was the definition of "psychiatric" or "psychological treatment." *Monitored*

MISCELLANEOUS

- HB 319 **Emergency medical and ambulance services. Deletes references to regional emergency medical services systems; increases grants and revises local matching requirements. *Monitored*. ADOPTED**
- HB 550 Concerned assisted suicides. *Opposed*
- HB 685 Established the position of "Inspector General" in the Attorney General's Office. The IG would be appointed by the Governor for a term of four years and be given broad authority to deal with a wide range of investigatory and prosecutorial activities. *Opposed*
- HB 774 Changed the method of carrying out a death sentence in Kentucky from electrocution to intravenous injection. No mention was made of physician involvement with the lethal injection. *Monitored*
- SB 124 Called for the state auditor to review the accounts of private corporations established or created to serve public entities funded primarily by tax dollars. *Opposed*
- SB 393 **Requires continuance of court ordered support while a child is in high school and until reaching the age of 19. *Monitored*. ADOPTED**

NURSING HOMES/LONG TERM CARE

- HB 371 Required minimum standards for the operation of boarding homes; required registration with the local fire and health departments. *Supported*
- HB 453 Created a Kentucky long-term care program to provide counseling services regarding long-term care needs. The bill imposed certain financial "matching" requirements under Medicaid and required the Commissioner of Insurance to adopt regulations establishing standards for long-term care insurance policies. It also attempted to regulate certain marketing practices, restrict exclusions, and prohibit policies from requiring prior hospitalization as a precedent to eligibility for long-term care benefits. *Monitored*

PHARMACY/PHARMACEUTICAL COMPANIES

- HB 132** Alters the Controlled Substances Act to conform to Kentucky's penal code. *Supported. ADOPTED*
- HB 153** Requires the label of every prescription dispensed by Kentucky pharmacists to bear the name, address, and phone number of the prescribing practitioner. *Monitored. ADOPTED*
- HB 380** Required manufacturers and wholesalers of drugs to register and obtain a license from the Kentucky Cabinet for Human Resources. CHR may adopt regulations and set fees for license issuance and renewal and must appoint a wholesale drug distributor advisory committee. *Monitored*
- HB 439** Created a new tax on marijuana and controlled substances which are manufactured, sold, etc., in violation of the Controlled Substances Act. *Monitored*
- HB 717** Repealed statutory authority for the manufacture of amygdalin (laetrile) in Kentucky. *Supported*
- HB 777** Allowed a physician to phone in prescriptions for Schedule II Controlled Substances in a defined "emergency situation." Established guidelines intended to conform to current federal regulations. *Opposed*
- HB 903** Dealt with the warnings which pharamacists and prescribing practitioners must give concerning potential adverse drug reactions. Pharmacists must place a warning on the prescription label if the manufacturer of a drug product has indicated the product's use is contraindicated with any other substance containing alcohol or that its use with another drug product would result in death. Prescribing practitioners must warn patients if prescribing a drug product about which the manufacturer has issued a warning that the drug's use is contraindicated with any other substance containing alcohol or that its use with another drug could result in death. The last provision of the bill related to a patient who is an alcohol or drug abuser. In that situation, the bill prohibited practitioners from writing a prescription for a drug product for which there is a warning that the product's use is contraindicated with any other substance containing alcohol. *Opposed*
- HB 904** Required that the labels of all prescriptions dispensed by Kentucky pharmacists reflect the "expiration date of the medication contained therein." *Monitored*

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- HB 928** Required that a prescription label show the name of the drug dispensed and clearly indicate if a generic drug was dispensed for a brand name drug which was prescribed. *Monitored*
- HB 929** Required that the label of every prescription dispensed by a Kentucky pharmacist contain an indication of the number of times per day the "prescribing practitioner recommends the medication be taken and the time of day, if any, during which the medication should be taken." *Monitored*
- SB 279** The Kentucky DEA bill mirrored federal law in all respects except for the provision dealing with record retention. The requirement in the bill was five years, while federal law requires retention for only two years. *Monitored*
- SB 421** Required the creation of a Medicaid Drug Utilization Review program; ten member board of five physicians and five pharmacists; purpose to enhance the quality of care through appropriate drug therapy. *Supported*

PRACTITIONERS

- HB 93** Expanded the scope of practice of specified ARNPs to include the prescription of legend drugs. Controlled substances were specifically excluded from this prescription authority. ARNPs allowed to prescribe must hold a Master's Degree, enjoy certain national certifications, and receive a certificate of fitness from the Board of Nursing. They must also complete at least five contact hours in pharmacology during each licensure period. *Opposed*
- HB 314** **Expands membership of the nurse practice council from nine to eleven by adding representatives from KAHCF and KHA.** *Monitored. ADOPTED*
- HB 323** Omnibus revision to the Nurse Practice Act. *Supported with amendment*
- HB 330** **Omnibus revision to the Psychologist Licensing Act.** *Monitored. ADOPTED*
- HB 340** **Makes technical, and essentially innocuous, changes in the social workers' licensing law.** *Monitored. ADOPTED*
- HB 345** Called for the certification of marriage and family therapists. *Monitored*

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- HB 420 Gains state recognition for students who attend chiropractic schools not currently accredited in Kentucky. *Monitored.* **ADOPTED**
- HB 421 Proposed certification of denturists in Kentucky. *Monitored*
- HB 473 Revises the licensing act for dentists and dental hygienists. *Monitored.* **ADOPTED**
- HB 528 Omnibus revisions to the practice of social work. *Monitored*
- HB 604 Omnibus revision to the hearing aid dealers licensing law. Prohibits against anyone other than a "specialist in hearing instruments . . . dispensing" hearing instruments without a license issued under KRS 334.080. The bill deletes requirements that either the physician or the audiologist member of the board be present in order for the board to conduct business. *Monitored with amendment.* **ADOPTED**
- SB 204 Created a new licensure category and bureaucratic structure for licensed professional counselors. *Opposed*
- SB 251 Changes the makeup of the local board of health by adding an optometrist and a licensed engineer to the board. Also establishes terms of office and requires removal of any member who fails to attend three consecutive meetings. *Opposed.* **ADOPTED**
- SB 422 Omnibus revision to the chiropractic licensure act. *Monitored.* **ADOPTED**

SAFETY

- HB 30 Prohibited operation of a motor vehicle on a public road or highway while passengers under the age of 18 are in an open or uncovered vehicular bed. There were exceptions for farm or agricultural activities, parades or similar events. **Supported per Resolution BB - 1989 House of Delegates*
- HB 96 Mandated that motor vehicle insurance companies give at least 20% discount on specified benefits where the insured is subject to a seat belt ordinance and has not been convicted of violation of that ordinance for the 12 month period immediately preceding the date of renewal or issuance of the insurance policy. The insured must refund the discount if involved in an accident and not restrained by a seat belt. The law is limited to areas where the seat belt ordinance establishes a penalty for its violation. *Monitored*

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- HB 110 Prohibited operation of "personal watercraft" while intoxicated or under the influence of drugs. **Supported per Resolution Q - 1989 House of Delegates*
- HB 169 Defined various watercraft and prohibited their operation while intoxicated. Also established alcohol limits, set up testing requirements and provided penalties for various violations. **Supported per Resolution Q - 1989 House of Delegates*
- HB 177 Related to boats and boating and prohibition against operation of such watercraft while intoxicated. **Supported per Resolution Q - 1989 House of Delegates*
- HB 460 Mandated use of seat belts in Kentucky. *Supported*
- HB 905 Established a motorcycle safety education program. *Supported*
- SB 256 Defined "personal watercraft" and prohibited their operation by anyone under the age of 16. **Supported per Resolution Q - 1989 House of Delegates*

SPORTS MEDICINE

- HB 750 Restricts high school varsity wrestling, soccer, and football to students who have successfully completed the eighth grade. **Supported per Report of Committee on School Health, Physical Education and Medical Aspects of Sports - 1991 House of Delegates. ADOPTED*

TOBACCO

- HB 352 Prohibits distribution of free samples of cigarettes or tobacco products to those under 21 years of age. Contains a prohibition against locating a billboard or sign advertising cigarettes or tobacco within 500 feet of elementary or secondary school property. Also prohibits sale of tobacco products to persons under the age of 18 and contains penalty provisions. *Supported. ADOPTED*

TORT REFORM

- HB 195 Allowed for collection of prejudgment interest if written notice of an intent to collect such interest was given to the defendant. Also expanded the definition of court costs, stating that the prevailing party in a civil action shall recover all costs, including filing fees, court reporter fees, fees for court approved expert witnesses and deposition fees. *Opposed*

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- HB 241 **Omnibus revision to the Kentucky Rules of Evidence. *Monitored***
ADOPTED
- HB 322 Allowed a loss of consortium claim for a child or parent when one or
the other is injured or killed. *Opposed*
- HB 757 Altered the Statute of Limitations in malpractice actions. Allowed a
claimant to bring suit for malpractice at any time within 180 days after
giving notice that he is considering bringing such an action, as long as the
claimant provided such notice prior to expiration of the one year S of L.
Opposed
- HB 771 Technical amendment to the Good Samaritan Act. *Monitored*
- HB 943 As amended would have repealed KRS 411.320 and thereby removed con-
tributory negligence as a bar (or defense) in product liability action.
Opposed
- SB 38 Allowed recovery of economic and non-economic losses in wrongful death
cases. *Opposed*
- SB 175 Amended Kentucky's wrongful death statute to allow consideration of a
variety of economic and non-economic damages in wrongful death actions.
Opposed
- SB 179 Amended Section 54 of the Kentucky Constitution to allow the General
Assembly to limit recovery in tort for non-economic loss and to prescribe
the manner in which damages shall be paid. *Supported*
- SB 419 Allowed non-economic damages to be awarded in certain Civil Rights
Actions. *Opposed*

WORKERS' COMPENSATION

- HB 544 **Relates to the Workers' Compensation assigned risk pool. Re-
quires submitting a statement for services rendered within 45
days of the treatment initiated. Requires the Commissioner of
Insurance to approve an insurer's refusal to offer a deductible
policy. *Monitored.* ADOPTED**
- HB 732 Created a public agency called the Kentucky Insurance Association to
provide Workers' Compensation coverage for Kentucky employers, espe-
cially those in the coal industry. *Monitored*

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- HB 794** Omnibus revision to Workers' Compensation Act. ***Monitored***
- HB 836** Proposed a state sponsored assigned risk plan for Workers' Compensation. Required all Workers' Compensation underwriters in Kentucky to participate in the plan and mandated that the Insurance Commissioner establish rates for those covered by the pool. The legislation established a bureaucratic mechanism for managing the plan, resolving disputes and dealing with requests for rate increases. ***Monitored***
- HB 911** Disqualified an injured employee from receiving Workers' Compensation benefits if, under certain circumstances, he had made false statements about his physical condition and medical history. Such a misrepresentation must be made knowingly and willfully; the employer must rely on that misrepresentation and there must be a causal connection between the false representation and the injury for which compensation is claimed. ***Monitored***
- SB 328** Required the Workers' Compensation Board to develop a schedule of fees for depositions and medical reports and statutorily prohibited balance billing. Insurance companies must notify the treating physician when payment of the bill will be delayed beyond 30 days and provide an explanation for failure to reimburse in the required time frame. Defined requirements for physicians who refer patients to facilities or services in which they have a financial interest. ***Monitored with amendment***

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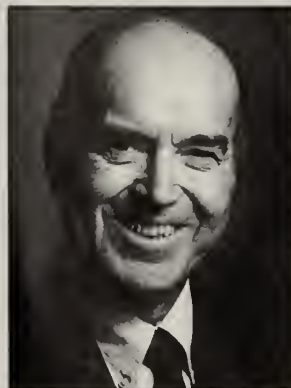
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and money to the business or industry
in which he is engaged. No person has
a moral right to withhold support from
an organization that is striving to
improve conditions within his sphere."*

— TEDDY ROOSEVELT

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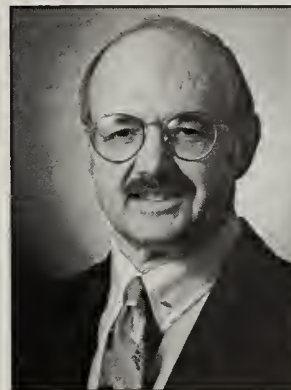
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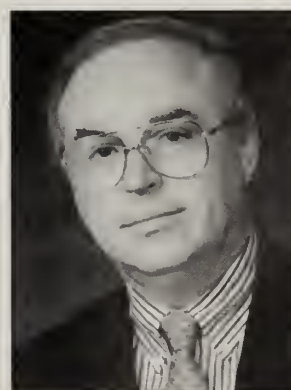
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